[COMMITTEE PRINT]

93D CONGRESS
2d Session

SENATE

REPORT
No. 93–

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

Supporting Paper No. 1

THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY

PREPARED BY THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

DECEMBER 1974

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*Appointed January 25, 1974, to fill vacancy on committee by resignation of William B. Saxbe (R. Ohio) from the Senate January 3, 1974.

PREFACE

Federal support of long-term care for the elderly has, within a decade, climbed from millions to billions of dollars.

What is the Nation receiving for this money?

This report explores that, and related, questions.

It concludes that public policy has failed to produce satisfactory institutional care—or alternatives— for chronically ill older Americans.

Furthermore, this document—and other documents to follow—declare that today's entire population of the elderly, *and their offspring*, suffer severe emotional damage because of dread and despair associated with nursing home care in the United States today.

This policy, or lack thereof, may not be solely responsible for producing such anxiety. Deep-rooted attitudes toward aging and death also play major roles.

But the actions of the Congress and of States, as expressed through the Medicare and Medicaid programs, have in many ways intensified old problems and have created new ones.

Efforts have been made to deal with the most severe of those problems. Laws have been passed; national commitments have been made; declarations of high purpose have been uttered at national conferences and by representatives of the nursing home industry.

But for all of that, long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system.

It is costly and growing costlier.

It is increasing in numbers, already providing more beds than there are beds in general hospitals.

And there is every reason to believe that many more beds will be needed because the population of old persons in this Nation continues to grow faster than any other age group.

Nursing home care is associated with scandal and abuse, even though the best of its leaders have helped develop vitally needed new methods of care and concern for the elderly, and even though—day in and day out—underpaid, but compassionate, aides in many homes attempt to provide a touch of humanity and tender care to patients who, though mute or confused and helpless, nevertheless feel and appreciate kindness and skill.

This industry, which has grown very rapidly in just a few decades—and most markedly since 1965, when Medicare and Medicaid were enacted—could now take one of three courses:

> It could continue to grow as it has in the past, spurred on by sheer need, but marred by scandal, negativism, and murkiness about its fundamental mission.

It could be mandated to transform itself from a predominantly proprietary industry into a nonprofit system, or into one which takes on the attributes of a quasi-public utility.

Or it could—with the informed help of Government and the general public—move to overcome present difficulties, to improve standards of performance, and to fit itself more successfully into a comprehensive health care system in which institutionalization is kept to essential minimums.

Whatever course is taken, it is certain that the demand for improvement will become more and more insistent.

Within the Congress, that demand has been clearly expressed in recent years. But often congressional enactments have been thwarted by reluctant administration, or simply have been ignored. Now, facing the prospect of early action upon a national health program for all age groups, the Congress must certainly consider long-term care a major part of the total package. Wisely used, the momentum for a total health care package could be used to insure better nursing home care.

Within the administration, there has been drift and unresponsiveness to congressional mandate since 1965. There are signs, however, that rising costs and rising public concern have aroused certain members of the executive branch to see the need for long-term care reform more clearly than before. Their actions and initiatives are welcome, but it is essential that the Department of Health, Education, and Welfare take far more effective, well-paced action than it has thus far.

Everywhere, the demand for reform is intensifying. People know that a nursing home could be in everyone's future.

They ask why placement in such a home should be the occasion for despair and desperation, when it should be simply a sensible accommodation to need.

The Subcommittee on Long-Term Care of the Senate Special Committee on Aging continually has asked the same question.

Care for older persons in need of long-term attention should be one of the most tender and effective services a society can offer to its people. It will be needed more and more as the number of elders increases and as the number of very old among them rises even faster.

What is needed now? As already indicated, the forthcoming debate over a national health program will offer opportunity for building good long-term care into a comprehensive program for all Americans.

But the issues related to the care of the chronically ill are far from simple. Tangled and sometimes obscure, technical questions related to such matters are reimbursement, establishment of standards, enforcement, and recordkeeping, often attract the attention of policymakers, to the exclusion of other questions, such as:

Could nursing homes be avoided for some, if other services were available?

What assurance is there that the right number of nursing homes are being built where they are most needed?

What measures can Government take to encourage providers themselves to take action to improve the quality of nursing home care?

What can be done to encourage citizen action and patient advocacy at the local level?

Such questions intrude even when the best of care is given. In other settings, however, scandal and calamity enter the picture; and dark new questions emerge.

The subcommittee, in this report and succeeding Supporting Papers, recognizes the importance of the nursing home industry; and it pledges every effort to continue communication with representatives of the industry and with members of the executive branch.

For these reasons, the subcommittee has devised an unusual format: After publication of this Introductory Report, a series of follow-up papers on individual issues will follow: then we will publish a compendium of statements invited from outside observers; after this will come our final report. In this way, the subcommittee can deal with the many parts needed to view long-term care as a whole.

Testimony from many, many days of hearings and other research have been tapped for this report, which is extensive and heartfelt. Concern about people has been at the heart of this effort. The subcommittee has, therefore, been especially dependent upon responsive staff effort. Mr. Val Halamandaris, associate counsel for the Senate Special Committee on Aging, deserves specific mention for his role in assuring that subcommittee inquiries remained directed at their real target: to wit, people in need of good care. Mr. Halamandaris has had the primary responsibility for directing the subcommittee's hearings; he is responsible for the excellent research on data and for writing this report. He is more than a skilled and attentive attorney; his investigatory skills are rooted in concern and, when necessary, outrage. He has made it possible for this subcommittee to compile and offer more information and insights into the nursing home industry than the Congress has ever had before.

He has been helped considerably by other committee personnel. Staff Director William Oriol has provided guidance and consultation leading to the design and special points of emphasis in this report. Committee Counsel David Affeldt has given generously of his legislative expertise, as well as painstaking attention to detail.

Particularly fortunate for the subcommittee was the fact that a professional staff member, John Edie, had special qualifications for making a substantial contribution to this effort. Mr. Edie, an attorney, formerly served as counsel to a program on aging in Minneapolis, Minn. When the subcommittee went to that city for intensive hearings on scandalous shortcomings in nursing home care there, Mr. Edie testified and then continued his efforts on behalf of reform. In the preparation of this report, he has worked closely and at length with Mr. Halamandaris and his associates.

The subcommittee also stands in debt to a select group in the nursing home industry and within the executive branch. Usually without much attention or encouragement, these public servants have stubbornly refused to compromise their goal, seeking high, but reasonable, standards of care.

With the publication of this Introductory Report, the subcommittee begins a final exploration of issues. We will publish responsible comments on findings expressed in this document and the Supporting

Papers which will follow. And we will, in our final report, perhaps 8 to 10 months from now, make every effort to absorb new ideas or challenges to our findings. The care of chronically ill older Americans is too serious a topic for stubborn insistence upon fixed positions. Obviously, changes are needed. Obviously, those changes will occur only when public understanding and private conscience are stirred far more than is now the case.

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

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PART 3

APPENDIXES

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

SUPPORTING PAPER NO. 1

THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY

ABOUT THIS REPORT

To deal with the intricate circumstances and governmental actions associated with nursing home care in this Nation, the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging is issuing several documents under the general title of *Nursing Home Care in the United States: Failure in Public Policy.*

An Introductory Report, published in November, declared that a coherent, constructive, and progressive policy on long-term care has not yet been shaped by the Congress and by the executive branch of this Nation.

Examining the role of Medicare and Medicaid in meeting the need for such care, the report found that both programs are deficient.

Further, it raised questions about current administration initiatives originally launched personally by President Nixon in 1971.

These shortcomings of public policy, declared the report, are made even more unfortunate by the clear and growing need for good quality care for persons in need of sustained care for chronic illness. It called for good institutions and, where appropriate, equally good alternatives, such as home health services.

(A more detailed summary of major findings from the "Introductory Report" appears later in this section of this report.)

Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," analyzes reasons for widespread concern—and even acute fear—about the care provided in nursing homes. It also gives specific examples of poor care or even abuses despite honest and often imaginative efforts—by the industry and by government—to eliminate such practices and to win widespread public confidence.

THE FACTUAL UNDERPINNING OF THIS STUDY

Fifteen years of fact-gathering preceded publication of this report. In 1959, the Senate Committee on Labor and Public Welfare established a Subcommittee on Problems of the Aged and Aging. Findings from subcommittee reports and hearings have been evaluated. That

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subcommittee acknowledged in 1960, as this report acknowledges in 1974, that nursing homes providing excellent care with a wide range of supportive services are in the minority.

With the establishment of the U.S. Senate Special Committee on Aging in 1961, additional hearings were conducted. The most recent phase began in 1969 with hearings on "Trends in Long-Term Care." Since 1969, 22 hearings were held and some 3,000 pages of testimony were taken, as of October 1973.

These hearing transcripts have provided valuable information and expert opinions, as have several supplementary studies by the subcommittee staff, the General Accounting Office and private groups such as Ralph Nader's Study Group on Nursing Homes in 1971. The Library of Congress and other congressional committees, as well as professional organizations such as the American Nursing Home Association, have also been helpful. Finally, a great portion of the data is from the Department of Health, Education, and Welfare and other administrative or independent agencies, such as the Securities and Exchange Commission. The assistance of State officials proved especially helpful.

ORGANIZATION OF THIS STUDY

The Introductory Report and this Supporting Paper will be followed by other Supporting Papers to be published at approximately monthly intervals over the next few months. Each will deal with a fairly specific issue, and each of these issues will be examined in the detail needed for understanding, not only by legislative and health specialists, but by laymen.

A study of this magnitude would be incomplete without reaction by the nursing home industry and by representatives of the executive branch. Accordingly, national organizations and appropriate governmental units will be invited to submit statements within 2 months after publication of the final Supporting Paper. Finally, the subcommittee will issue a concluding report intended to update earlier information and to analyze the situation at that time.

The format is unusual, perhaps unprecedented. But the nursing home industry is too vital a part of our health system and of the national scene for lesser treatment.

MAJOR POINTS OF THIS SUPPORTING PAPER

The subcommittee's Supporting Paper No. 1 reveals the following were the most important nursing home abuses:

- **Negligence leading to death and injury;**
- **Unsanitary conditions;**
- **Poor food or poor preparation;**
- **Hazards to life or limb;**
- **Lack of dental care, eye care or podiatry;**
- **Misappropriation and theft;**
- **Inadequate control of drugs;**
- **Reprisals against those who complain;**
- **Assault on human dignity; and**
- **Profiteering and "cheating the system."**

The inevitable conclusion is that such abuses are far from "isolated instances." They are widespread. Estimates of the number of sub-

standard homes (that is, those in violation of one or more standards causing a life-threatening situation) vary from 30 to 80 percent. The subcommittee estimates at least 50 percent are substandard with one or more life-threatening conditions.

These problems have their roots in contemporary attitudes toward the aging and aged. As Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care, has said:

> It is hell to be old in this country. The pressures of living in the age of materialism have produced a youth cult in America. Most of us are afraid of getting old. This is because we have made old age in this country a wasteland. It is T. S. Eliot's rats walking on broken glass. It's the nowhere in between this life and the great beyond. It is being robbed of your eyesight, your mobility, and even your human dignity.

Such problems also have their roots in the attitudes of the elderly toward institutionalization. Nursing home placement often is a bitter confirmation of the fears of a lifetime. Seniors fear change and uncertainty; they fear poor care and abuses; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and "going on welfare." To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

However, these arguments cannot be used to excuse nursing home owners or operators or to condone poor care. Those closest to the action rightly must bear the greatest portion of responsibility.

To deal with the litany of abuses, action must be taken immediately by the Congress and the executive to: (1) Develop a national policy with respect to long-term care; (2) provide financial incentives in favor of good care; (3) involve physicians in the care of nursing home patients; (4) provide for the training of nursing home personnel; (5) promulgate effective standards; and (6) enforce such standards.

MAJOR POINTS OF INTRODUCTORY REPORT (ISSUED ON NOV. 19, 1974)

Medicaid now pays about 60 percent of the Nation's $7.5 billion* nursing home bill, and Medicare pays another 7 percent. Thus, about $2 of every $3 in nursing home revenues is publicly financed.

There are now more nursing home beds (1.2 million) in the United States today than general and surgical hospital beds (1 million).

In 1972, for the first time, Medicaid expenditures for nursing home care exceeded payments for surgical and general hospitals: 34 percent to 31 percent.

Medicaid is essential for growing numbers of elderly, particularly since Medicare nursing home benefits have dropped sharply since 1969. Average Social Security benefits for a retired couple

*Introductory Report revised, based on Research and Statistics Note; Dept. of HEW, Social Security Administration, Office of Research and Statistics, Note No. 32–1974, Nov. 29, 1974.

now amount to $310 a month compared to the average nursing home cost of $600. Medicaid (a welfare program) must be called upon to make up the difference.

The growth of the industry has been impressive. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and expenditures for care by 465 percent. Measured from 1960 through 1973, expenditures increased almost 1,400 percent.

Despite the heavy Federal commitment to long-term care, a coherent policy on goals and methods has yet to be shaped. Thousands of seniors go without the care they need. Others are in facilities inappropriate to their needs. Perhaps most unfortunate, institutionalization could have been postponed or prevented for thousands of current nursing home residents if viable home health care and supportive services existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients—as well as substantially less expensive—the Department of HEW has given only token support for such programs.

Despite the sizable commitment in Federal funds, HEW has been reluctant to issue forthright standards to provide patients with minimum protection. Congress in 1972 mandated the merger of Medicare and Medicaid standards, with the retention of the highest standard in every case. However, HEW then watered down the prior standards. Most leading authorities concluded at subcommittee hearings that the new standards are so vague as to defy enforcement.

There is no direct Federal enforcement of these and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the enforcement system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.

The President's program for "nursing home reform" has had only minimal effect since it was first announced in 1971, and actions in 1974 fall far short of a serious effort to regulate the industry.

The victims of Federal policy failures have been Americans who are desperately in need of help. The average age of nursing home patients is 82; 95 percent are over 65 and 70 percent are over 70; only 10 percent are married; almost 50 percent have no direct relationship with a close relative. Most can expect to be in a

nursing home over 2 years. And most will die in the nursing home. These patients generally have four or more chronic or crippling disabilities.

Most national health insurance proposals largely ignore the long-term care needs of older Americans. Immediate action is required by the Congress and executive branch to improve past policies and programs which have been piecemeal, inappropriate, illusory, and short-lived.

MAJOR POINTS OF FORTHCOMING SUPPORTING PAPERS

Supporting Paper No. 2

"DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS"

According to most studies, the average nursing home patient takes 4.2 different medications each day. However, more recent studies reveal that the average may be seven medications, or perhaps even higher. Prescriptions for nursing home patients typically total $300 per year, more than three times the cost for the noninstitutionalized elderly. In 1972, drugs accounted for 10 percent of all nursing home expenditures—$300 million in all.

And yet, the flow of drugs through many of America's 23,000 nursing homes is largely without controls. It is haphazard; it is inefficient; and it does not help the patient desperately dependent upon others for protection when put in a state of semisleep or outright unconsciousness.

Supporting Paper No. 3

"DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY"

Physicians have, to a large degree, shunned the responsibility for personal attention to nursing home patients. One of the reasons for their lack of concern is inadequate training at schools of medicine. Another is the negative attitude toward care of the chronically ill in this Nation. Medical directors are needed in U.S. nursing homes and will be required in HEW regulations effective January 1976. The subcommittee's May 1974 questionnaire to the 101 U.S. schools of medicine indicates a serious lack of emphasis on geriatrics and long-term care.

Eighty-seven percent of the schools indicated that geriatrics was not now a specialty and that they were not contemplating making it one; 74 percent of the schools had no program by which students, interns, or residents could fulfill requirements by working in nursing homes; and 53 percent stated they had no contact at all with the elderly in nursing homes.

Supporting Paper No. 4

"NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)"

Of the 815,000 registered nurses in this Nation, only 56,235 are found in nursing homes, and much of their time is devoted to administrative duties. From 80 to 90 percent of the care is provided by over 280,000 aides and orderlies, some few of them well trained, but most literally hired off the streets. Most are grossly overworked and paid at or near the minimum wage. With such working conditions, it is understandable that their turnover rate is 75 percent a year.

One reason for the small number of registered nurses in nursing homes is that present staffing standards are unrealistic. The present Federal standard calls for one registered nurse coverage only on the day shift, 7 days a week, regardless of the size of the nursing home. By comparison, Connecticut requires one registered nurse for each 30 patients on the day shift, one for every 45 in the afternoon; and one for each 60 in the evening.

A serious national shortage of nurses still persists, despite training programs.

Supporting Paper No. 5

"THE CONTINUING CHRONICLE OF NURSING HOME FIRES"

In 1971, there were 4,800 nursing home fires; 38 persons were killed in multiple death fires and some 500 more in single death fires. An estimated $3.5 million loss was directly attributable to nursing home fires.

Nursing home patients are especially vulnerable to fires. Many are under sedation or bound with restraints. Physical infirmities and confusion often cause resistance to rescue.

There is reason to believe the number of nursing homes failing to meet fire safety standards is actually increasing.

In 1971, the General Accounting Office reported that 50 percent of U.S. nursing homes were deficient in regard to fire safety. A January 1974 study by the U.S. Office on Nursing Home Affairs said that 59 percent of skilled nursing facilities are certified with deficiencies. HEW spokesmen indicated that in excess of 60 percent of intermediate facilities do not comply with existing standards. The requirements are on the books, but they are not heeded. Even more dramatically, the GAO 1974 study indicates 72 percent of U.S. nursing homes have one or more major fire deficiencies.

Supporting Paper No. 6

"WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS IN LONG-TERM CARE"

It is unjust to condemn the entire nursing home industry. There are many fine nursing homes in America. A growing number of administrators are insisting upon positive approaches to therapy and rehabilitation, innovations in physical structure of the physical plant; employee sensitivity training and cooperative agreements with local schools of nursing; and even self-government and other activities for the patients.

"Ombudsmen" programs have been established by Presidential direction and are making some headway. In some States, the nursing home industry has launched an effort to upgrade its facilities by establishing directories, rating systems, and a "peer review" mechanism. These efforts offer the prospect of improving nursing home conditions if conducted in a vigorous and effective manner. In Chicago, nursing homes have a "cool line" telephone number for relatives, visitors, or patients who have complaints.

Supporting Paper No. 7

"THE ROLE OF NURSING HOMES IN CARING FOR DISCHARGED MENTAL PATIENTS"

Thousands of elderly patients have been transferred from State mental institutions to nursing homes. The number of aged in State mental hospitals decreased 40 percent between 1969 and 1973 according to subcommittee data, dropping from 133,264 to 81,912. This trend is caused partially by progressive thinking intended to reduce patient populations in large impersonal institutions. Another powerful reason, however, may be cost and the desire to substitute Federal for State dollars. It costs the States an average of $800 per patient per month to care for mental patients in State hospitals while these same individuals can be placed in boarding homes at a substantially reduced cost. Charges of "wholesale dumping" of patients have been made in several States. Acute problems have been reported, most notably in California, Illinois, and New York.

Supporting Paper No. 8

"ACCESS TO NURSING HOMES BY U.S. MINORITIES"

Only 4 percent of the 1 million nursing home patients in the United States are members of minority groups, even though their health needs are proportionately greater. Part of the problem is caused by cost obstacles or lack of information about Medicaid.

Discrimination is the greatest obstacle to greater utilization by blacks. But discrimination need not be overt; often relatives are made to feel that their parent or grandparent would not be made comfortable. In the case of Asian-Americans and Spanish-speaking Americans, language barriers often cause insurmountable difficulties. Cultural and other problems, including rural isolation, cause problems to American Indians.

Members of minority groups at subcommittee hearings have been sharply critical of the Nixon administration's nursing home "reforms." They protested the "arbitrary and punitive" closing of a few minority owned nursing homes that do exist and the absence of assistance to help upgrade standards.

Supporting Paper No. 9

"PROFITS AND THE NURSING HOME: INCENTIVES IN FAVOR OF POOR CARE"

Profits by nursing homes have occasioned serious and persistent controversy. Nursing home administrators say that Medicaid reimbursement rates are low and that they can hardly become the basis for profiteering. Critics say that the economics of nursing home operation, supported in such large measure by public funds, should be examined more closely and publicly than they now are.

On the basis of available evidence, including a subcommittee survey made in 1973–74, the subcommittee has learned that the 106 publicly held corporations controlled 18 percent of the industry's beds and accounted for one-third of the industry's $3.2 billion in revenue (as of 1972). Between 1969 and 1972 these corporations experienced the following growth:

- 122.6 percent in total assets;
- 149.5 percent in gross revenues; and
- 116 percent in average net income.

One recent HEW study, however, shows marginal rates of return in a sample of 228 nursing homes. Thus, the issue is far from settled. But a joint study—conducted by the General Accounting Office and the subcommittee—suggest significant increases in total assets, revenues, and profits for individual operators as well.

Two final documents will be issued as part of this study: A compendium of statements by the industry and administration spokesmen, and a final report by the Subcommittee on Long-Term Care.

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NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

SUPPORTING PAPER NO. 1

THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY*

—Ordered to be printed

Mr. Moss, from the Special Committee on Aging, submitted the following

REPORT

INTRODUCTION

Any examination of nursing home care in the United States must recognize three unfortunate but vital facts:

—Older persons have a generally negative attitude toward such institutions, so much so that emotional and even physical damage can occur with nursing home placement.

—Their fear is based partially on their own personal predicaments: diminished capacities, the reluctance to give up "independent living" for fixed institutional routine, and the likelihood that they will remain to the end of their days in this new and threatening environment.

—But their response is also based upon a more general concern: they are victims, as are other generations, of a national revulsion against well-publicized nursing home neglect and abuses.

So much attention has been given to the problems and scandals related to nursing home care that many witnesses have described such facilities as a symbol of society's neglect of the elderly. Ralph Nader said that happenings in nursing homes are one very dramatic expression of an overall "geriatric segregation" which affects *all* elderly in their many roles as consumers, residents, and relatives:[1]

> There is a colossal amount of collective callousness that pervades the society from the organizational to the individual levels. *The most intense focus of what has been wrought for old people is the nursing home.* (Emphasis added.) The few homes that are humane, competent, and mindful of their residents' need for activity and meaning to their day, provide a staggering gap between what an affluent society should attain and what is, too frequently, the reality for most nursing homes.

* As explained in "About this Report," a series of documents, all under the general heading of *Nursing Home Care in the United States: Failure in Public Policy*, is being issued by the Subcommittee on Long-Term Cure, U.S. Senate Special Committee on Aging. An Introductory Report was issued on Nov. 19, 1974. A series of supporting papers, beginning with this document will be issued approximately at monthly intervals.

[1] "Trends in Long-Term Care", part 11, hearings by the Subcommittee on Long-Term Care, Washington, D.C., December 17, 1970, p. 872.

Mr. Nader's line of reasoning and similar views expressed by other commentators are sometimes criticized by those who say that "only 5 percent" of the elderly are in institutions at any one time, and more attention should be paid to the vast majority of older persons who can meet their own needs without "outside" help.

But, as was seen in the Introductory Report, the 5 percent estimate is misleading because: (1) It indicates the number in institutions at any one time and does not indicate changes in patient number throughout a year; (2) the odds are good that anyone who lives to a fairly advanced age will spend at least some time in a nursing home; and (3) with the accelerating increase in the 75 plus population, the nursing home population is almost certain to increase, even with the establishment of satisfactory "alternatives" which would head off or reduce institutionalization.

The importance of nursing home care in the United States, however, cannot be assessed by numbers of patients or prospective patients, impressive as these numbers may be.

To the Subcommittee on Long-Term Care it is clear that the quality of care offered to older persons with long-term illnesses *is* a measure of our society's concern for the well-being of *all* our citizens for *all* of their lives.

No matter what other improvements are made on behalf of the elderly—in retirement income, in social services, in the very way in which they are regarded by younger generations—their existence will be tainted by fear as long as the prospect of despair and suffering within nursing home walls remains fixed in their view of the years ahead.

This subcommittee, therefore, affirms that it is working fundamentally toward wholesome and positive attitudes toward nursing home care and toward the building of a secure place for the nursing home industry within our health care system. For that reason, the subcommittee has, and will continue to, emphasize positive advances in the quality of care and in progressive action by government and by nursing home operators.

But the subcommittee cannot ignore the very real tragedies which occur frequently enough to divert attention from the achievements of the industry and turn attention instead to the dark sides: abuse, negligence, and loss of life.

For these reasons, in Part 1 of this Supporting Paper, the subcommittee examines in detail the persistent reports of shoddy and inhumane treatment. (Separate papers deal with the care of discharged mental patients, fatal fires, and the use of drugs in nursing homes.)

Part 2 considers the question of how many nursing homes can be classified as substandard; that is, how many have serious or life threatening violations of standards? Are the characterized abuses, "isolated instances" as the industry contends, or do they reflect general industry trends?

Part 3 examines root causes for the neglect, and worse, in many nursing homes in hopes that it will provide deeper understanding of atmosphere which tolerates or perhaps even encourages the outrages so frequently reported in the news media and explored further at congressional hearings and by official agencies.

PART 1

THE LITANY AND DIMENSIONS OF NURSING HOME ABUSES

In his December 1970 testimony before the Subcommittee on Long-Term Care, Ralph Nader introduced the members of his task force on nursing home problems and concluded that with the exception of the work of this subcommittee:

> The full scope of nursing home abuses and profiteering has yet to be told. Although the Federal Government pours over a billion dollars a year into this $2.5 billion industry through Medicare and other subsidy programs, there have neither been the full-fledged congressional hearings, nor the enforcement of adequate Federal and State standards, nor the administrative inquiries and disclosures that are needed to reduce the institutional violence and cruelty that are rampant. Such moves have not occurred in spite of major fire disasters, fatal food contaminations, corporate manipulations, drug experimentation beyond proper medical discretion, kickbacks in drug sales for the residents, abysmal lack of medical supervision, and strong evidence that such abuses are more epidemic than episodic.[2]

The nursing home industry responded, attacking not the conclusions of the Nader Report, but the credibility of the members of the task force. The industry suggested that: (1) The teenagers who investigated nursing homes were untrained and inexperienced; and (2) they might have a tendency to overreact to what they observed in nursing homes. Industry spokesmen labeled the alleged abuses as "isolated instances." Only one nursing home association, the National Council of Health Care Services, responded to the subcommittee's invitation to comment on the merits of the report's conclusions; the council agreed that many of the conclusions were valid.[3]

The foregoing response was similar to those made by the industry to each of the more than 50 major newspaper exposés on nursing home problems published in the past 10 years. For example, in Sep-

[2] Pages 872–73, part 11, hearings cited in footnote 1.
[3] Pages 968–75, part 11, hearings cited in footnote 1.

tember 1969, the *St. Petersburg* (Fla.) *Times* ran articles by two reporters who had worked several weeks in Florida nursing homes. In testimony before this subcommittee, the president of the Florida Nursing Home Association charged the stories were unfair, unrepresentative and offered by untrained individuals who knew little about nursing homes.[4]

As a result of the *Times* stories, the Florida Legislature created the ad hoc committee on nursing homes, chaired by State Senator Louis De La Parte.

Asked specifically about the *Times* series and the findings of the State's investigation, Senator De La Parte stated:

> While the publicity which the unfavorable conditions have received has tended to overshadow the efforts of those providing good service, the material printed by the *St. Petersburg Times* has been largely substantiated. It has generally been fair and accurate and has succeeded in focusing not only the attention of government, but also the attention of the private sector on the critical need for improvement.[5]

Similarly, the *Chicago Tribune* and the Better Government Association joined forces in early 1971 to investigate local nursing homes. The investigators worked in or visited many nursing homes and published their fundings. Heated denials were issued by spokesmen from the Metropolitan Chicago Nursing Home Association. They charged the series was politically motivated, and that the disclosures were made "by untrained observers and reflect, in part, lack of knowledge. They are, so far, unsubstantiated by any responsible agency . . . we would be foolish to deny the possibility that . . . a fringe percentage of 'undesirable' practices may occur." [6]

At subcommittee hearings in April 1971, the *Tribune*-BGA charges were supported by the Chicago Board of Health, which admitted that 45 percent of its nursing homes had serious violations.[7] Additional verification came from the Cook County Department of Public Health and the Illinois State Department of Health, which conceded that 50 percent of the nursing homes in their jurisdictions did not meet minimum standards.[8]

Elsewhere, the *Milwaukee Journal*, in August 1970, charged that 43 of the 99 nursing homes in Milwaukee County had serious violations. In 1971 the Lieutenant Governor of the State of Wisconsin released the results of his extensive investigation and confirmed the *Journal's* findings.[9]

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[4] Pages 214–17, part 2, hearings cited in footnote 1.
[5] Page 164, part 2, hearings cited in footnote 1.
[6] Page 1543, part 15, hearings cited in footnote 1, see also, appendix 2, p. 239.
[7] Page 1124, part 12, hearings cited in footnote 1.
[8] Pages 1037, 1050, and 1058, part 12, hearings cited in footnote 1.
[9] *Nursing Home Investigation,* Report to Gov. Patrick J. Lucey (Wisconsin), December 8, 1971.

The point is that the charges of newspapers should not be dismissed out of hand, particularly where the reporter has "inside" information from health department inspectors (Wisconsin), or where they have worked as nursing home employees (Florida), or where they have worked in conjunction with an impartial investigatory body with access to State and city inspection records (Illinois).

In fairness it should be pointed out that newspaper reports often make major points in emotional terms. But the great similarity of the charges leveled against nursing homes by newspapers across the Nation suggests that some of the chronic problems plaguing the industry are far from "isolated instances."

In sorting through many newspaper exposés and findings of official investigatory bodies, the subcommittee discovered the following patterns of abuse, starting with the most frequently mentioned (see table, p. 168, for more details) :

Lack of human dignity; lack of activities; untrained and inadequate numbers of staff; ineffective inspections and enforcement; profiteering; lack of control on drugs; poor care; unsanitary conditions; poor food; poor fire protection and other hazards to life; excessive charges in addition to the daily rate; unnecessary or unauthorized use of restraints; negligence leading to death or injury; theft; lack of psychiatric care; untrained administrators; discrimination against minority groups; reprisals against those who complain; lack of dental care; advance notice of State inspections; false advertising.

The subcommittee's investigations from 1963 through 1974 revealed much the same pattern of abuse as established by the press. However, the bulk of the complaints received fell into the category of poor patient care. Of necessity, the subcommittee deals with problems, and this concern sometimes may give the impression that there is little positive achievement in the nursing home field. Nothing could be further from the truth.

In fact, a major goal of the investigation was to emphasize the positive, to provide examples of the best homes in America to serve as models of the future. Supporting Paper No. 6 will reflect this effort.

A description of the most common nursing home abuses, received by the subcommittee, follows.

INCIDENCE OF MOST COMMON COMPLAINTS AGAINST NURSING HOMES AS REPORTED IN THE GENERAL NEWSPAPER INVESTIGATIONS

	San Diego Union, 1971	Chicago Tribune, 1971	Philadelphia Bulletin, 1968	New York Daily News, 1962	Milwaukee Sentinel, 1970	Newsday, L.I., N.Y., 1970	Boston Globe, 1968	St. Petersburg (Fla.) Times, 1969	Associated Press series, 1969	Nashville Tennessean, 1965	Reader's Digest, 1972	New York Times, 1970	Boston Herald Traveler, 1971	Baltimore Sun, 1971
Negligence Leading to Death or Injury		X		X				X	X	X	X			
Bribery					X									
Intention Physical Injury	X	X						X	X		X			
Untrained Administrators		X				X		X				X		X
Poor Care	X	X		X	X	X	X	X	X			X	X	
Non-Profit Homes are Better	X				X	X					X	X		
Poor Food	X	X	X	X	X	X	X	X	X	X	X	X		
Profiteering	X	X	X		X	X	X	X	X		X	X	X	
Unsanitary Conditions	X	X	X	X	X	X		X	X	X	X		X	
Refusing to Take Heavy Care Patients	X	X	X									X		X
Excessive Charges in Addition to Basic Rates	X	X			X			X						X
Fire or Other Hazards		X	X			X	X		X	X		X		
Lack of Dental Care					X			X						
Lack of Psychiatric Care				X	X			X	X	X				
Lax Control of Drugs	X	X	X	X	X	X		X	X	X	X	X	X	
Untrained and Inadequate Personnel	X	X	X	X	X	X	X	X	X	X	X	X	X	X
False Advertising									X					
Absentee Ownership		X												X
Lack of Human Dignity	X	X	X	X	X	X			X	X	X	X	X	X
Lack of Activities	X	X	X	X	X	X			X	X	X	X	X	X
Theft	X	X	X						X	X	X			
Lack of Podiatry									X	X				
Doctors Absent	X	X	X	X	X	X	X		X	X	X	X	X	X
Unnecessary or unauthorized use of Restraints	X		X						X	X		X		
Ineffective Inspections - Lax Enforcement	X	X	X		X			X	X	X	X	X	X	X
Advanced Notice of Inspections									X	X				
Discrimination Against Minority Groups	X		X						X					
Reprisals Against Patients who Complain		X	X						X					
Use of unlicensed Homes to House Patients (the bootleg nursing home)	X	X	X								X			

—Analysis prepared by subcommittee staff.

Almost all nursing homes have at least one of them; some nursing homes have all of them; the vast majority fall somewhere in between. Some of the instances described took place in 1974. Others took place a few years ago. However, the examples were carefully chosen and were not used unless the principle illustrated is still valid today. The recurrence and continuity of abuses over many years is in itself significant.

I. ABUSE AND POOR TREATMENT OF PATIENTS

Negligence is conduct which is careless; it is a breach of duty which results in injury to a person or a violation of his rights. Under the law, those injured by such wrongful conduct may sue and collect damages from those who cause such injury.[10] Negligence on the part of nursing home personnel can lead to dire consequences:

- A California resident notified the subcommittee of her mother's death from dehydration subsequent to an improper dose of insulin resulting in diabetic coma. She charged that her mother was in a coma for 24 hours unnoticed until she visited and then called her private physician.[11]
- One patient died in a Chicago, Ill., nursing home not from the heart condition from which she was paralyzed but from the pneumonia contracted as a result of a window left carelessly open by nursing home personnel.[12]
- Mrs. G. C.'s mother's foot went unattended in another Chicago nursing home. Despite the daughter's repeated pleas for staff attention to her mother, she watched her mother's foot blacken, and develop gangrene. It was finally amputated.[13]

In addition, Illinois Department of Health files reveal:

- A patient left unattended in a Chicago nursing home was allowed to drink and smoke. She fell asleep, spilling liquor in her lap, and then dropped a lit cigarette. She became a human torch.[14]
- One patient was found by a family member tied to a chair running a 106-degree temperature. She died the next day.[15]
- A patient was found starving and dehydrated by a member of the family. She died the day after she was found.[16]

An official of the New York Health Department provided the following:

- Mrs. L. N. complained to the department that her mother who suffered from paralysis, was scalded by an aide trying to give her a bath. The patient died within a week.[17]
- A 74-year-old patient fell out of her wheelchair, where she was left. An occupational therapist, passing by, suggested to staff person Z that the patient be picked up. Staff member refused and

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[10] "Nursing Home Law Manual." Health Law Center, Aspen Systems Corp., 1971, Negligence Chapter, p. 1.
[11] Letter in committee files from Mrs. S. G., October 1, 1970.
[12] Page 991, part 12, hearings cited in footnote 1.
[13] Pages 999–1002, part 12, hearings cited in footnote 1.
[14] Report in committee files dated, December 31, 1970.
[15] Page 1019, part 12, hearings cited in footnote 1.
[16] Page 1019, part 12, hearings cited in footnote 1.
[17] Letter from Ruth Bennett, New York Department of Mental Hygiene, to John A. Edie, professional staff member, Senate Special Committee on Aging, October 5, 1972.

insisted that patient would be "OK" lying on the floor. The occupational therapist reported this to her superior who brought it to the attention of charge personnel. When the occupational therapist went to her car the next day, which was in the parking lot allocated to all staff, her four tires, she observed, had been slashed. The patient, it was later learned, suffered a fractured hip as a result of the fall and died shortly thereafter.[18]

The Wisconsin State Division of Health confirmed:

- A patient entered a nursing home in March 1972 in stable condition. By November 1972 she had deteriorated drastically. She was transferred to the hospital suffering from dehydration and a bed sore infected down to the bone. She was in or near a state of shock, and she subsequently died.[19]
- A patient was severely weakened after losing 18 pounds in 1 month. The same patient had not received a bath for periods in excess of 3 weeks.[20]
- At the subcommittee's Minnesota hearings one witness testified:

> There was another patient who had trouble walking to the bathroom. He was not incontinent when he came. He had no problem urinating, he just needed some assistance walking to the bathroom. One day the day shift decided to catherize him anyway. The day shift orderly put a catheter in him. The first catheter drew blood instead of urine. So he took it out thinking there was something wrong with the catheter. So he tried another one. The same result happened. He told me personally to watch the patient because he was bleeding a little bit from the penis. Later on that evening a clot came through his penis that filled the whole bottom of the bed pan. Two or three days later he was sent to the hospital. He died there.[21]

- Another witness testified:

> One of the patients there was a retired dentist whose name I do not remember. His wife was dead and he had no relatives or friends that I know of. He had been treated for a bed sore by a heat lamp. Whoever had put the heat lamp on him had forgotten about it and just left it there. When I came on duty I had to treat him, and he had third-degree burns on his back. I was not there when the burns were incurred, but I did take care of the problem when I was on duty.[22]

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[18] See source cited in footnote 17.

[19] Report of the Wisconsin Nursing Home Ombudsman Program, January 7, 1974, p. 5.

[20] Page 2, report cited in footnote 19.

[21] Page 2227, part 19A, hearings cited in footnote 1.

[22] Page 2334, part 19B, hearings cited in footnote 1. These examples are merely illustrative. A great many more can be found in the subcommittee's hearings and files. For example, the Minnesota hearings were designed specifically to quantify nursing home abuses in a State with a reputation for high quality health care facilities. These hearings provide additional references from numerous sworn statements received by the subcommittee. For more examples of negligence, see the following pages of part 19B of hearings cited in footnote 1: Abramson, 2232, 2234; Bozych, 2236; Carter, 2240; Finney, 2247, 2250–51, 2255; Fox, 2258; Gardas, 2267; Harms, 2270; Heininger, 2275; Hurwitz, 2285; Kleppinger, 2305; Krueger, 2308; Meyer, 2323; McAllister, 2327; Schallberg, 2334; Stage, 2336; Shypulski, 2338, 2341–42; Tenney, 2343; Tretheway, 2345; Van Dyke, 2346, 2348; Walker, 2351.

See also the testimony of the Nader Task Force on Nursing Homes, page 880, part 11, of hearings cited in footnote 1; testimony of Oscar Walsh, page 572, part 7, of hearings cited in footnote 1; and the results of the Baltimore Salmonella epidemic in 1970 when 36 patients died; in parts 9 and 10 of hearings cited in footnote 1.

Still more examples can be found in the Nation's case law. See for example *Hendricks* v. *Sanford* where the plaintiff sued a nursing home for failure to keep her bed clean. The

II. DELIBERATE PHYSICAL INJURY

The responsibility of the nursing home for injuries caused to patients is not limited to acts of negligence. The home is also liable for deliberate or intentional conduct causing injury to another. For instance, an administrator could be charged with false imprisonment—which is the unjustified denial of another's freedom of movement—if he were to prevent a patient from leaving the nursing home until he paid his bill.[23] It is just as clear that a home will be liable for corporal punishment or other deliberate injury of patients caused by the home's personnel.

Two especially dramatic examples of intentional injury were provided by State Senator Catherine Carswell of Maine and confirmed by the attorney general of that State.

- She testified:

> Having been greatly enlightened by the State police report, and shocked at the same time, I requested the attorney general's department to investigate the nursing homes situation. The attorney general's report was made after a brief investigation, and it would make your blood chill. It included the smothering to death of a patient who obviously was in a coma and taking too long to die. The operator wanted to go on a shopping trip, but wanted to be present when the funeral director came for the patient. A pillow was used to smother the patient.
>
> Another patient who had been up and around when last seen by the witness, was in a coma when seen next. Reports were that the patient became difficult, so she was thrown on the bed and started screaming. A washcloth was stuffed in her mouth, and a bath towel placed over her face. She was held down until a shot of morphine became effective. Every time the patient showed signs of rallying, she was given a shot of morphine. She drowned in her own fluids, her chest was so filled up.[24]

- The Illinois Department of Health files report that:

> A female patient who was 93, totally blind, and a severe cardiac, was put into a chair with restraints despite doctor's

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patient eventually developed near fatal bedsores. *Elliot* v. *Tempkins,* 299 NYS 2d 857, 1969, involved a nurse who placed a paralyzed patient on a commode, tied him down and then left him to serve other patients lunch. The patients cigarette dropped onto his clothes and caught fire. During the several minutes the aide was gone, the patient was unable to extinguish his clothes or to get off the commode and burned to death. *Ferguson* v. *Dr. McCarty's Rest Home,* 142 N.E. 2d 337, 1957, concerned a paralyzed patient who suffered severe burns when her foot came into contact with a radiator that was at bedside. The patient screamed for an hour before the nurse could, "pull herself together" and rescue her charge. *Smith* v. *Silver Spring-Wheaton Nursing Home,* 220 A. 2d 574, 1966, involved an action against a nursing home for hiring an allegedly insane practical nurse who beat up a patient. In another landmark case, *Dunahoo* v. *Brooks,* 128 So. 2d 486, 1961, the court held a nursing home liable for injuries suffered by a 94-year-old woman patient who tripped and fell over a light cord lying loose on the floor by her bed.

[23] Pages 19–20, chapter on the administrator, source cited in footnote 10. The case of *Big Town Nursing Home* v. *Newman,* 461 S.W. 2d 195, is cited concerning a patient who was admitted under an agreement that he "would not be forced to remain against his will." When the patient attempted to leave, he was prevented from doing so. It was testified that he had tried to escape on five or six occasions. Each time he was caught and returned to the home. The patient was sometimes locked and taped in a restraint chair for as long as 5 hours although there is no evidence that the patient's mental or physical condition warranted restraining devices. The nursing home was found guilty of falsely imprisoning the patient by restraining him without legal justification.

[24] "Problems in the Nation's Nursing Homes," part 7, hearings by the Subcommittee on Long-Term Care, Portland, Maine, August 13, 1965, pages 746–47.

orders that she should be in bed. The day after she entered H. Nursing Home, an attendant struck her in the face with her fist to punish her for spilling a cup of water. Her attending physician called the woman's daughters and had them remove her from the home. She was transferred to her home and died a week later. The inspection nurse closed her memo by telling how she had tried to convince the operators to close the home the year before, even though the State had relicensed them. She did not feel the elderly couple ran an adequate nursing home.[25]

- In 1972, a New York Department of Health official reported that:

A female patient in Institute X (a chronic-care facility) . . . was shouting and asking to get out of bed . . . whereby staff person Y tied, bound, and gagged her in her bed and before leaving the bedside, struck her on the face. Sometime later that week, patient died.[26]

* * * * *

Female patient, aged 66, asked to be taken to the toilet since she could not get there without aid. Her request refused each time she asked, she began to cry and plead wherby staff member C punched her in the face causing blackened eyes and a bleeding nose. Though this was observed by other staff personnel, when staff member who was involved was questioned by her superiors in regard to the incident, she claimed that "patient fell and that's why her eyes are black." [27]

- In 1973, the Minnesota Health Department reported:

It was determined that a gangrenous toe of a patient was removed by an orderly on September 10, 1973. There is no documentation in the patients' chart to indicate that the doctor was notified before or after the incident occurred. The charting of the incident was done by a nurse's aide. Both the orderly and the nurse's aide were interviewed by the surveyors. The orderly stated he did remove the toe which he claimed was nearly severed at this time anyway but that he believed the nurse in charge had notified the doctor and also had his approval, however, there is no documentation to this effect. The patient is still at the facility, her foot is three-fourths gangrenous, she has several bed sores and is severely contracted.[28]

- In January 1972 a nursing home administrator and a nurse's aide in a Washington, D.C., nursing home were charged and later convicted of murder. The apparent motive was that the administrator had forged the deceased's name in cashing one or more civil service retirement checks. The patient knew this and threatened to make trouble.[29]

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[25] Page 1017, part 12, hearings cited in footnote 1.
[26] See source cited in footnote 17.
[27] See source cited in footnote 17.
[28] Report by Anthony Kist, chief, standards compliance section, Minnesota Department of Health, September 17, 1973.
[29] *Washington Post*, January 8, 1972.

- An Iowa witness testified in 1971, giving these examples:

> Our program has been responsible for closing up some of these nursing and custodial homes. One instance—where these people had been beaten by laths taken from the side of a home, where plaster has been put over it—I know; and can testify to this, definitely, that it is true. I have seen the lath marks on the bodies of 80-year-old women.
>
> I know that these people go hungry. I know that they lie there day after day in their own filth. I know that they have their mouths taped shut with adhesive tape—because they dared to ask for a bedpan at 2 o'clock in the afternoon, while the aides played cards. I know this to be a fact.[30]
>
> * * * * *
>
> We put a person in there [the nursing center operating without a license] for 3 days to gather the evidence. Not only did we get that evidence but we had the direct sworn testimony and notarized testimony of an elderly person who saw this man's face shoved in a plate of mashed potatoes. When he arrived at Broadlawns Hospital at 11 o'clock in the morning, a part of the mashed potatoes were still in his mouth. He died that night at 6:20 and the diagnosis was diabetic coma.[31]

- In Utah, the license of a nursing home operator was revoked in 1970 because she allegedly struck and injured patients with a wooden 2 by 4.[32]

III. UNSANITARY CONDITIONS

Unsanitary conditions can be extremely dangerous. They may spread a virulent infection, as in cases presented to the subcommittee where food handlers did not follow proper hygienic procedures; where kitchen preparation equipment was left uncleaned; or where food was left out in the open at room temperature prior to being served. Perhaps the most tragic example of probable food poisoning was the 1970 Baltimore Salmonella epidemic, which claimed 36 lives. The suspected cause was shrimp and deviled eggs left sitting at room temperature.[33] There have been reports of nursing homes using inadequate amounts of soap in their laundry, exposing patients to potential cross-infection. Specific examples follow:

- The chief dietician of Cook County, Ill., testified with respect to "one of the worst homes in the county":

> On that visit I found that the home was filthy and there was

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[30] "Evaluation of Administration on Aging and Conduct of White House Conference on Aging", part 4, joint hearings by the Special Committee on Aging and the Subcommittee on Aging of the Labor and Public Welfare Committee, Washington, D.C., March 31, 1971, p. 240.

[31] Page 240–241, part 4, hearing cited in footnote 30.

[32] The L.H.M. Rest Home, Ogden, Utah. For other examples given under oath, see part 19B of hearings cited in footnote 1 (especially Marotz, p. 2317: "I have seen charge nurses and aides slap patients on the hands and face. If we complain to the charge nurse about young aides slapping patients, the charge nurse says not to worry about it because the patients probably deserve it.") : Brown, 2239; Finney, 2252; Grew, 2266; Gruss, 2269; Hawkins, 2273, Henry 2278, 2280; Krueger, 2308; Lace, 2310; Marotz, 2317; Meyer, 2323; Paton, 2332; Shypulski, 2339; and Tenney, 2343.

[33] Parts 9 and 10, hearings cited in footnote 1.

fecal material on the stairs. They were carrying the laundry right through the kitchen at serving time and the food and the laundry were in full sight of each other.[34]

- An employee in a South Dakota nursing home wrote to the subcommittee:

> I have witnessed and been a party to unsterile, unclean techniques in handling medications, dressings, and laundry. I have witnessed techniques of self care among the staff possibly responsible for the spread of infections among the patients. These include aides serving breakfast, lunch, and dinner (in addition to their personal care functions) instead of food handlers; aides and orderlies being responsible for laundry at night.[35]

- A former patient in an Arkansas nursing home complained:

> They administer the medication in plastic cups and instead of throwing them away, they wash them out and use them over and over again. Since they are plastic there is no way to sterilize the cups. Colds or viruses pass through the whole center in this manner. We also have plastic water jars, unmarked as to patients, and these are taken up ever so often and you never get your jar back, but someone else's jar. There is no way to sterilize the jars.[36]

- A patient in a Washington State nursing home said:

> A time came when the odors of the halls became so bad that a grandson who came to help with my therapy on weekends . . . suddenly gagged, pushed me to a chair, and fled in panic for a moment. These prevailing odors were covered with sprays. . . . The total effect was simply a new smell. I never saw any antiseptic used in the slap-dash cleaning that was done.[37]

- In 1970, the Detroit Health Department reported that a dead body was allegedly kept for 2 days near the center's food handling area; that fecal matter was found in a patient's bureau drawer and that patients were allowed to sit in their own waste on mattresses that were soiled with urine and feces.[38]

- The son of a patient who died in the Baltimore, Md., Salmonella epidemic wrote:

> Our own experience with mother constantly evidenced dried and caked food on her eating table, constant accumulation of dust on her dresser and her wardrobe, dusty floors in the room, lack of toilet tissue in the toilets and lack of towels and washcloths and a lack of regular change of linen.[39]

- Official inspection reports in Wisconsin report one home was "overrun by flies. They were crawling over the tables where patients eat and were in patients rooms."

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[34] Page 1044, part 12, hearings cited in footnote 1.
[35] Letter from J. B., May 6, 1973, in subcommittee files.
[36] Letter from I. D., November 25, 1971, in subcommittee files.
[37] Letter from J. W., in subcommittee files.
[38] See *Detroit Free Press*, "Charges Build Up At Home," November 21, 1970, p. 3A.
[39] Letter from J. F. H., August 25, 1970, in subcommittee files.

• Another report reads:

> When we arrived at the nursing home, the odor of urine was pronounced.
>
> The patients had commodes in their rooms and they were being used instead of bathrooms.
>
> In Room No. ——, where Mr. ———— lives, the commode toilet was encrusted with fecal material. The floor was sticky with a jellylike substance.
>
> Mr. ———— was sitting in a wheelchair with a urine-stained hospital type gown on. The urine stain extended to the shoulders.
>
> I requested that (he) be given a bath and clean clothing.[40]

• Wisconsin inspection files in December 1972 report that in one home, baths were not given once a week as required. On the contrary, many patients had no baths for intervals up to 3 weeks. One man had only 2 baths in his 10-week stay and both of those were at his specific request.[41]

The subcommittee's Minnesota hearings generated the following sworn testimony.

• A nursing home patient testified that:

> The bathroom condition in the nursing home was filthy. I was on the third floor where all the senile and mental patients were. They mixed senile with the normal. There were two bathrooms on the floor, but both bathrooms were used by men and women. Some of the patients were not too careful when they went to the bathroom. As a result I had to walk with my bandaged foot in urine on the floors of the bathroom.
>
> I had the janitor bring me a bunch of clean rags, which I hid under my mattress. Then I would take two or three rags with me when I went to the bathroom, to tie them on my walker as I made my way to the bathroom. I didn't have very good balance, so when I got there I would drop one rag on the wet places and try to mop up the mess with the legs of my walker. I was not able to bend over very well to do this. Then I would use another rag to put down by the toilet to put my feet on. They were wrapped in gauze, you know. The third rag I used, after wetting it, to wipe up the toilet seat that many times was full of feces.[42]

• An orderly testified:

> As I entered the second floor, the first thing that I would see were puddles of urine all up and down the hall and as I walked down the hallway my shoes would squeak on the urine on the floor. My feet literally stuck to the floor. This was the condition all up and down the hallway, not one night, but every single night I went to work at 2200 Park Nursing Home.

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[40] Quoted in *Milwaukee Journal*, "Inside Our Nursing Homes," by Gene Cunningham, April 9, 1970. p. A1.

[41] Letter of December 14, 1972, from Lt. Gov. Martin J. Schreiber to Robert A. Palifito, president, National Health Enterprises, enclosing a December 11, 1972, report by George H. Handy, M.D., Wisconsin State health officer.

[42] Page 2101, part 19A, hearings cited in footnote 1.

The only exceptions on this floor were the rooms where residents were not incontinent. But even in these rooms there was a sticky trail of urine where the resident walked to and from the bathroom.

The fact that urine and feces were so visible on the shift that I worked is appalling, and in order to walk into some rooms I had to put towels on the floor. This is not true of only one night I worked, but every night.[43]

- In 1973 the Minnesota Health Department confirmed a complaint of unsanitary conditions at a Minneapolis nursing home, finding "many floors were messy and sticky, janitors' closets were very dirty." Upon interviewing the housekeeping staff, inspectors learned that they were employed less than a week, having no training, orientation, or previous experience.[44]

IV. POOR FOOD OR POOR PREPARATION

Food is more than sustenance for nursing home patients; it is a happening, the major event of each day. Some nursing homes offer excellent meal services but many do not. Poor food, more often than not, results from a desire to save money or from improper training of food handlers.

The complaints received by the subcommittee run the gamut from watery soup and small portions, all the way to charges that unwholesome food was served.

The subcommittee received testimony that the uneaten portion of meals was being scraped off one patient's tray and put on a new plate for a second person[45]; that some meals consisted of one-half slice of bread, a little squash and coffee; that meals such as "mock meatloaf" (cottage cheese and cereal) were served.

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[43] Page 2102, part 19A, hearings cited in footnote 1.

[44] Report by Anthony B. Kist, chief, standards and compliance section, April 12, 1973. For more examples, see sworn statement of Orderly Shypulski, page 2124, part 19A, hearings cited in footnote 1: The laundry people are blind. The linen came up from the laundry as dirty as they went down. The linen is all torn, raveled, it is stained with urine and medication stains. It is just filthy, it is just not clean. It is yellow and gray. I have many a time taken a sheet out of the linen closet, a clean sheet, opened it and laid it on the bed and here would be dry feces in the sheet, mangled right into it.

There is also a shortage of linens. I have had to put patients to bed in their clothes because there are no linens, draw sheets, diapers, or gowns.

From part 19B of hearings cited in footnote 1, see Kippels (p. 2299): There was another patient by the name of Mr. ——— who had a staph infection. Staph infections are very contagious. Mr. ——— was very senile, and he was also a diabetic. This man was not treated in any way. We tried our best to keep him clean and get him cleaned up and to warn others to wash their hands after working with him. It was very hard to do this, however, because we had no way to sterilize anything on the 3rd floor. This infection that Mr. ——— had, was all over his legs, and yet he walked around barefoot. Most of the patients walked around barefoot. The Staph infection would be seeping down his leg and onto the floor. He would scratch himself and then go around touching things. This had gone on for a year or so, and he was in and out of the hospital, and it just kept continuing. Mr. ——— would go around eating off of people's trays while they were eating and before they were eating. Mr. ——— was a diabetic, and he would eat anything off of these trays, and sometimes he would walk around with a pocketful of sugar. Mr. ——— was not naturally mean, but if he wasn't fed right and he got hungry, he got very mean. We never had any trouble with him because we tried to see that he was kept from being too hungry. We knew how to talk to him and keep things out of his way.

From part 19B, see also: Abramson, 2231–3; Biller, 2235; Craft, 2241; Danielson, 2242; Eyford, 2245; Finney, 2246, 2256; Fox, 2261–3; Grew, 2267; Cardas, 2267–8; Harms, 2270–1; Hawkins, 2273; Heininger, 2276; Henry, 2277, 2279; Johnson, 2289; Jones, 2290; Lang, 2311; Larsen, M., 2314; Larsen, W., 2317; Marotz, 2318; Meyer, 2323; Schallberg, 2333; Stage, 2337; Villas, 2350; Shypulski, 2342; Tenney, 2343; Tretheway, 2345; Van Dyke, 2348.

[45] Pages 1012, 1086–87, part 12, hearings cited in footnote 1.

Through its subpena power the subcommittee learned that one administrator spent 54 cents per patient per day for food while jails in the Chicago area spent 64 cents a day.[46]

There are examples of injuries induced by aides trying to feed individuals who had suffered some paralysis and of patients literally starving to death because they could not swallow.[47]

There were examples of patients who had choked to death when served hard-to-chew foods such as beef bacon.[48] There were examples of patients not receiving special diets ordered by physicians in contravention of Medicare standards. Diabetics, for example, were served pancakes with regular syrup or the same meal as other patients except they did not get any dessert.[49]

In July 1970, a Salmonella food-poisoning epidemic at the Gould Convalesarium in Baltimore, Md., claimed 36 lives. A blue-ribbon panel was appointed by the State to investigate this tragedy.

The panel's report stated:

> What should elicit concern . . . is that the nursing home was not an exceptionally bad one and that the potential for such an occurrence is even greater in one of the many substandard homes we have in this country.

The report concluded:

> **. . . the recent events at the Gould home could be repeated at virtually any nursing home in the State, unless the broader, general problems are faced and corrected. (Emphasis supplied.)** [50]

The following examples are from subcommittee files. It is worth noting that the Senate Committee on Nutrition has prepared a lengthy report on inadequate nutrition and poor food offered by U.S. nursing homes.[51]

- At the subcommittee's Chicago hearings, chief investigator Bill Recktenwald of the Chicago Better Government Association testified that he served 37 patients his first day of work in a local nursing home. He added:

> The dinner consisted of a very small portion of lettuce with some type of dressing, a small portion of applesauce, a cup of coffee, one toasted cheese sandwich and a small bowl of soup. Each patient received some milk.
>
> On occasion the food . . . that food was taken from one patient's plate by the help [that worked for you] and moved over to another person's plate to use up, to fill that plate or put the portion on it and sometimes it was moved even a third time.[52]

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[46] Pages 1251–52, part 13, hearings cited in footnote 1.
[47] Page 2303, part 19B, hearings cited in footnote 1.
[48] Page 2251, part 19B, hearings cited in footnote 1.
[49] Page 2298, part 19B, hearings cited in footnote 1.
[50] "Report of an Investigation into the Salmonella epidemic at Gould Convalesarium in Baltimore in July, 1970 by a Board of Inquiry Appointed by the Secretary of Health and Mental Hygiene of Marlyand," October 27, 1970, reprinted in part 10 of hearings cited in footnote 1, pages 837–47.
[51] *Nutrition in the Nation's Nursing Homes,* a report by the Senate Select Committee on Nutrition, as yet published.
[52] Pages 1086–87, part 12, hearings cited in footnote 1.

- A spokesman from the New York Department of Health reported:

> A female, approximately 82 years old, is blind and lacking in acute taste sensitivity. She had told all ward personnel that she intensely disliked hamburgers and would not eat them. Staff member D, several times each week, in bringing patient her dinner, would erroneously tell her that the meat was hamburger meat no matter what it was, whereby patient would not eat it. Staff member D would then eat her meal.[53]

- A consumer advocate testified with respect to Iowa nursing homes:

> These people are hungry; they are afraid. They are afraid to say one word, because, they are afraid if they do object their welfare funds will be cut off. We know of instances where this has actually happened.[54]

- The Wisconsin State inspection records in 1970 disclosed:

> The refrigerators were filthy, spilled food, cracked dirty eggs with liquid in a pan. . . . The nurse could not make up menus because of lack of food, especially no meat, in the home.
>
> The nurse stated that patients had not been served meat for a week . . . . The personnel in this home are very concerned about the patients and have spent their own money, up to $13, to buy food for the patients.[55]

- Medicare certification was repealed for a Texas nursing home partially because: (1) patients needing help in eating were ignored; and (2) adaptive self-help devices to aid patients in feeding themselves were not available.[56]

- A relative of a California patient wrote of one home:

> The patients do not get enough protein and calcium. . . . The cook prepared bacon for her father and all the patients smelled it and asked for some. [The administrator] said he was sorry he could not afford to serve bacon, however, he would serve it if the family brought it in. That I did, for the last month mother had bacon with breakfast. She lost 16 pounds in the 5 months and 5 days she was in there.[57]

- A Utah nursing home administrator testified:

> Some operators have bragged that adequate nutrition can be provided for a patient at the cost of $20.55 a month. I have been assured that others require less. 67% of the patients at . . . [our nursing home] required special diets. If a high protein menu is maintained and special diet requirements are met, the cost of food service will require much more than this.

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[53] See source cited in footnote 17.
[54] Page 240, part 4, hearings cited in footnote 30.
[55] See source cited in footnote 40.
[56] Report from Thomas M. Tierney, Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, September 28, 1971, to Magic Valley Geriatrics Center, in McAllen, Tex., in Subcommittee files.
[57] Letter from E. J. B. of July 16, 1974, in subcommittee files.

> The cost of milk alone for 3 glasses a day at wholesale prices will cost $8.10 a month. Any reasoning person can imagine the amount and the quality of food the patient receives.[58]

• A registered nurse from Washington reported that average food cost for the State's nursing homes was under $1 in 1970 while jails received much higher food allowances—perhaps as much as $3 a day.[59] Data supplied to the committee by the General Accounting Office with respect to 90 nursing homes (30 each in Tennessee, Colorado, and Massachusetts), revealed that 22 of the 90 homes surveyed (or 24 percent) spent less than $1 per patient per day in 1971. Only one home in each of the three States (3 percent) spent more than $2 a day for food. *One home spent 37 cents a day in 1969, 40 cents a day in 1970, 37 cents per day in 1971, and 52 cents per patient per day in 1973.*[60]

The following examples are from the subcommittee's Minnesota hearings:

• One registered nurse testified:

> As for food out there, dogs eat better. My mother got a puree tray. She got two tablespoons of meat, four tablespoons of squash, and then one scoop of dry potatoes. And this was the meal every day, the same thing over and over again. I brought jello and tapioca and bread from home every day to supplement her food.[61]

• An orderly reported:

> Sometime around the middle of September, the home served hot oatmeal for breakfast. There were worms in the oatmeal. This was not the first time that worms had been found in the food. It usually happens on and off during the summer. On this particular day in September I had passed out all of the trays to the people who could feed themselves. When I got the tray for one of the male patients that I fed, I put the sugar on his cereal and started to get a spoonful when I noticed something black in the oatmeal. I looked at it closer and found out that it was a black bug. I looked more carefully through the cereal and I found a lot of bugs in it. I found some smaller white bugs with black heads. I immediately went down and reported this to the kitchen. We tried to get as much of the oatmeal away from the patients as we could, but many of them had already eaten it. The cook told me that she had taken the meal from an open box that was kept in the kitchen area.
>
> One time they made Kool-aid with soap.
>
> One thing that I forgot to mention about the bugs in the cereal was that when the head nurse, Miss Bustamante, found out about it, she said to feed it to them anyway.[62]

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[58] Page 572, part 7, hearings cited in footnote 1.
[59] Letter from L. L. D. of December 15, 1970, in subcommittee files.
[60] See Supporting Paper No. 9.
[61] Page 2284, part 19B, hearings cited in footnote 1.
[62] Page 2318, part 19B, hearings cited in footnote 1.

- An aide spoke of her experience:

> I'd like to tell you about that beef bacon. It looked more like corned beef bacon and many times the patient would run to the desk and we'd have to reach our fingers in and pull it out of their throats before they'd choke. So we complained so much to the cook about this bacon she finally stopped sending that bacon to the floor.
>
> Back by the dishwasher, Mr. Thayer has instructed the dishwashers to have a container there. Everything that comes back like butter, eggs, sugar, what-not, they are to put in this container. It is reused.
>
> One Sunday they served baked chicken and mushoom gravy for the main dish. After it was served, that is, the dinner meal, they refrigerated it. The next day they took it out and was going to serve it for the supper meal. They changed their minds and did not serve it. They didn't refrigerate it. They didn't serve it on Tuesday, but on Wednesday evening they served it. Every one of those patients got sick, and I was one of the victims, too.[63]

V. MISAPPROPRIATION AND THEFT

Theft and misappropriation is quite common in nursing homes, according to complaints received by the subcommittee. Almost anything can be stolen: electric razors, clothes, jewelry, liquor, drugs, radios, or televisions. There is evidence strongly suggesting that many

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[63] Page 2126, part 19A, hearings cited in footnote 1. In the same hearings, page 2125, see testimony of nurse's aide Kippels:

The food at this home was a big joke. Patients were always complaining about being hungry. They had one time what they called a mock meatloaf. Mrs. Finney and I thought it looked very good when we were serving the trays. We went down on our lunch break. I tasted it and spit it out. It was the most horrible tasting thing I have ever had in my life. I kind of laughed, joked, the cook was in the kitchen and he was laughing at the same time. . . . I asked him what was in it. He said cottage cheese and cereal. Most of the plates came back to the kitchen not touched. . . . The meat there was very, very tough. They constantly served weiners in that nursing home, weiners and pancakes was the main diet there; very high carbohydrate foods, macaroni, cheese, weiners, pancakes, and salad. . . . They also had a stamp scale in their kitchen. This stamp scale, I am sure you have seen one, very small, it was used to weigh the meat on. When we saw it sitting there we asked the cook. She said, "Can you imagine, they expect me to weigh the meat for each patient on this stamp scale."

We also set up trays on the third floor. We'd go in and clean up patients because we were so short-staffed. We would have to go from cleaning a patient, which many times involved cleaning feces or bad infections, bed sores and so on, directly into the kitchen. In the kitchen, the bread would come up in a loaf. We would take the bread out, put it on the tray, pour the milk into a juice glass and pour the coffee. Most of the glasses on the floor were so badly stained with medications or were just generally dirty that we threw them out. This left us many times without glasses. Sometimes we'd wash them the best we could so all the patients could get their milk.

They also had a refreshment cart that was served in the evening between the time they ate their supper meal and before they went to bed. This refreshment cart consisted of peanut butter sandwiches and watered-down Kool-aid. Once in a great while we'd get juice, but it was not too often. People on the third floor had difficulty eating peanut butter sandwiches because most of them were without teeth.

See also part 19B, hearings cited in footnote 1: Abramson, 2233; Biller, 2235; Danielson, 2242; Eyford, 2245; Finney, 2248, 2251; Fox, 2257, 2261–63; Gorczyca, 2265; Gardas, 2268; Gruss, 2269; Henry, 2279; Hurwitz, 2281, 2283, 2284; Johnson, J., 2289; Lang, 2311; Marotz, 2318; McAllister, 2327; Nepenin, 2331; Paton, 2332; Shypulski, 2342; Tenney, 2344; Tretheway, 2345; Van Dyke, 2348; Villas, 2349.

See also page 880, part 11, hearings cited in footnote 1, for Nader Task Force examples including: "On the lunch trays there were two dried fishsticks and some mashed potatoes and some pureed peas (everyone got pureed peas regardless of whether they were on a special diet or not). There was also a chunk of very dry cornbread. While one nurse was wheeling several trays down the hall to the patients' rooms (all of them bedridden) another nurse walked by and swiped some cornbread off of a few trays and ate it."

patients are not receiving welfare allotments designated as personal spending money. Property of the nursing home, including food and equipment, is sometimes stolen. Sometimes, patients themselves misplace certain items. Examples follow:

- The 1972 Maryland Governor's Commission on Nursing Home Problems charged in its report that there was little consistency as far as techniques for handling personal spending money.[64] Dean Daniel Thurz of the University of Maryland stated:

> Money is being accumulated that belongs to the patients without the patients being able to spend the money . . . it is a scandalous situation and a major violation of the rights of the individual.[65]

- In 1973, the director of the Idaho Nursing Home Ombudsman program charged that the handling of patient's funds was one of the most pervasive of nursing home abuses. In Idaho, the money the State pays welfare patients for their own use is called the "canteen fund" and amounts to $17.50 a month. The director charged that this money allotted for personal effects was being used by nursing homes, which he charged kept improper accounts of other money belonging to patients.[66]

- Similar charges were received by the subcommittee in 1965,[67] in 1969 [68] and in 1971, at the Minnesota hearings.[69] It was stated that some patients, especially those mentally competent who aggressively claimed their personal expense money, generally had no trouble in getting it. Others less ambulatory or less competent never received their allotments.[70] It was also reported that some nursing homes charged patients for laundry, room cleaning, changing sheets, etc., when these charges should be included in the flat rate the nursing home received from the State. Two examples from the Minnesota hearings follow:

- A nurse's aide testified that:

> Many of the men for whom we asked for underclothing were incontinent. They walked around with their pants on and no underclothes underneath. We never did get underwear for the men and women, and they would get very red and raw underneath because of their incontinence. Many people walked around with no socks on, and even some with foot problems walked around with shoes on but no socks on, just shoes. I went down to ask Mr. Thayer for these things many times. One time he told me. "Well, their family should bring these things for them". I suggested to him that he use the allowance that the welfare patients get which is either $9 or

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[64] Preliminary Report on the Governor's Commission on Nursing Home Problems, June 30, 1972. p. 19.
[65] *Washington Evening Star-News*, May 14, 1972.
[66] *Idaho Statesman*, January 20, 1973. p. 14.
[67] Page 111, part 2, hearings cited in footnote 24; also page 704, part 6, hearings cited in footnote 24.
[68] Testimony of William D. Ginn, President, Cleveland Welfare Federation, before the Senate Finance Committee in support of S. 1661, October 23, 1969.
[69] Page 2340, part 19B, hearings cited in footnote 1.
[70] See *New York Times*, "Nursing Homes Are Nursing Scandals", October 13, 1974 sec. 4, p. 10; and letter from Mr. Paul M. Allen, director, bureau of medical assistance, Michigan Department of Social Services, to Mr. Val J. Halamandaris, September 16, 1974.

$11 a month. I suggested that he use this money to buy various things like underclothes and socks and then dole it out to the patients and charge them for it. He thought this was a good idea, but he never did it. Where their allowances from welfare are going I really don't know. But I can say this, that on the 3rd floor, the whole time I was working up there, the nursing home never bought one thing for any of those patients.[71]

- A relative testified:

Money was stolen from Mrs. . . . while she was in this home. Mrs. . . . had a little money in her billfold. Bud would see to it that she always had a little money to spend if she needed it. She got $9 a month from the welfare and he'd always give her a little bit more in case she wanted to get a permanent or something. At one point she had about $50 in her billfold because she wanted to get her hair fixed and buy a few things. So Bud wanted to make sure she had enough money so that on the week end she could do what she needed to do. But Mrs. . . . never did get a chance to go down to do that at that point, and a few days later she told Bud that she didn't want to keep that much money around and would he please take $35 out of there and leave her $15. Bud said OK and went over to get the money and it was all gone, someone had taken it. . . . She had unfortunately no place to lock this money up, and at one point someone stole over $100 from her. She was so upset from this that she didn't sleep for a week.[72]

- On the matter of the theft of possessions, the Minnesota hearings provided these examples:

Often they will leave the home without their teeth, without their rings, watches, and without any personal effects which they had come in with. One patient bought a brand-new suit because he knew he was going to die before too long. When he died he left the home without that suit. It was never found. . . . Employees regularly take food and groceries from the home.[73]

* * * * *

Of the welfare money allotted to the patients, they are allowed to keep $2 with them on the floor. Any more than that is kept in the office. If they go to the hairdresser, the transaction is then carried through the business office. However, there was a woman who received $5 for a Mother's Day present. They talked her into putting the money in the office. She agreed and was assured that she could get the money any time she wanted. When she wanted to send it to a grandson, someone went down to get it and they were told that the $5 had

[71] Page 2296, part 19B, hearings cited in footnote 1.
[72] Page 2313, part 19B, hearings cited in footnote 1.
[73] Pages 2318–19, part 19B, hearings cited in footnote 1.

been taken because the husband owed the nursing home $25. Now he owed them only $20.[74]

* * * * *

On the second day that my husband was in the home after I had brought these clothes in, all the long underwear was gone except for two pairs; all the dress shirts were gone; all the slacks were gone; all the pajamas were gone; all the socks were gone; and all the handkerchiefs were gone.[75]

- Ida Mae Dentler, chairman, citizens committee, H.E.L.P. (Helpless Elderly Lonely People), from Houston, Tex., wrote to the subcommittee:

Some large nursing homes have found it necessary to hire armed guards to protect their property at night. Is this any indication when they question the integrity of their staff which is 90 percent unlicensed and uncontrolled by a State agency? Perhaps the administrators will tell you about their annual loss in groceries, linens, drugs, and other supplies. We wonder what, if anything, is ever done about the losses reported by the patients, like diamond rings, cash money, clothes, and other valuable possessions. Are the police ever called in to investigate robberies or accidental deaths from burns, scaldings, and head injuries? [76]

- A relative of a patient stated:

A patient is never sure when they awake, where their things will be.[77]

VI. INADEQUATE CONTROL OF DRUGS

The lack of control of drugs is one of the most critical and far-reaching problems confronting the nursing home industry. Some experts suggested that 60 percent of the patients in nursing homes have inadequate pharmaceutical services.[78] In order to present this problem in perspective a full supporting paper will be devoted to this topic. A few examples are provided here to indicate the nature of the problem:

- In 1973, the U.S. Bureau of Health Insurance charged that there was inadequate control of drugs in one Wisconsin home. They found:

—Untrained aides giving medications.
—No narcotics count as required by law.
—Medications prescribed for one patient were used for others.
—Charting was incomplete.
—Many patients missed doses.

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[74] Page 2310, part 19B, hearings cited in footnote 1.
[75] Page 2241, part 19B, hearings cited in footnote 1.
[76] Letter of June 18, 1971, from Ida M. Dentler, Chairman, Citizens Committee H.E.L.P. (Helpless Elderly Lonely People) to Director of U.S. General Accounting Office.
[77] Letter from A. W. of October, 1971, in Subcommittee files. For more examples of theft and misappropriation, see part 19B, hearings cited in footnote 1; Bozych, 2238; Craft, 2241; Finney, 2252; Hurwitz, 2283; Krueger, 2308; Lace, 2310; Lehman, 2313; Larsen, M., 2315; Larsen, W., 2317; Marotz, 2319; Moriority, 2326; McAllister, 2327; Paton, 2332; Tenney, 2344; Tretheway, 2345; Villas, 2349.
[78] Testimony of Dr. Allen Kratz, President, American Society of Consultant Pharmacists in part 22, hearings cited in footnote 1.

—The facility was short 300 medication doses during one weekend.
—Medication and narcotics storage containers were not locked, contrary to law.
—Some medications and treatments were given without physician's orders.
—Outdated drugs no longer in use were not destroyed, contrary to regulations.[79]

- The Bureau of Health Insurance decertified two facilities in Michigan; in one home they determined that:

> Treatment and medication orders are not being carried out, medications are being charted as being administered when the medication is not available in the facility.[80]

In the other, they reported:

> No incident reports are written for medication errors, some medications are given without physician's orders, telephone orders are not always signed within 48 hours, some medications containers are not properly labeled and the emergency kit is not properly sealed, and the practice of the director of nursing rewriting medications orders that are not countersigned by the physician and relaying these orders to the pharmacy leads to confusion and possible error.[81]

- BHI decertified another facility in California in late 1971, in part, because, "In some instances it was found that medications had been administered which had not been ordered by a physician." [82]
- During the subcommittee's Minnesota hearings a licensed practical nurse testified:

> I was the only nurse on at night, and all the staff at this home had keys to the medicine room and to the narcotics cabinet. The Medications Room was never locked. All the aides had keys to this room. They never kept count of the narcotics in this home, They would borrow one narcotic prescription to replace another, and then they would never replace the one they borrowed from. Contrary to what law requires, this home did not destroy medications that belonged to patients who died. They kept them in a special cabinet.
>
> One time on the afternoon shift before I came on, apparently a new aide who had no experience and did not know the floor at all was just given the medications to distribute. She, not knowing what to do exactly, went through room by room just passing out the medications as she went, and when she was through she was out of medications but there was still one

[79] Statement of Deficiencies and Plan of Correction prepared by surveyors Constance King, John Brennan, and Stephen Schlough of the Bureau of Health Insurance, Social Security Administration, Department of Health, Education, and Welfare, June 6, 1973. Survey made of Mount Carmel Nursing Home of Greenfield, Wisconsin.

[80] Report from Thomas M. Tierney, Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, September 28, 1971, to Fairlane Memorial Extended Care Facility, Detroit, Michigan, in Subcommittee files.

[81] Report from Thomas M. Tierney, Director Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, September 28, 1971, to Avonside Nursing Home, Inc., Detroit, Michigan, in Subcommittee files.

[82] Report from Thomas M. Tierney, Director, Bureau of Health Insurance, Department of Health Education, and Welfare, Social Security Administration, September 27, 1971, to Ygnacio Convalescent Hospital, Walnut Creek, California, in Subcommittee files.

room left. Therefore, when I came on I was told to keep an eye on all the patients in all the rooms in case there were any reactions to mixed up drugs that night. None of this was ever put on the charts.[83]

In March 1973, the Minnesota Health Department confirmed similar activities at another home, verifying a complaint that aides were allowed to prepare dosages and administer medications.[84]

- The LPN mentioned above also underscored a common complaint concerning overtranquilization:

> This nurse would also deliberately increase the dosage of a sedative much higher than the prescription in order to quiet down patients, but then she would put on the chart that she had administered the required dosage. She would take sedatives from the prescriptions of other patients in order to do this.[85]

- This same problem has come to the attention of the National Council of Senior Citizens. Mr. William R. Hutton, executive director, testified:

> The National Council of Senior Citizens urges the medical profession to move against this insidious evil. We likewise ask the Federal Government and the States to insist on standards of care in nursing homes and homes for the aged that will prevent wanton use of tranquilizer drugs as a substitute for proper care and treatment.
>
> Abuse of tranquilizer drugs in nursing homes has become so flagrant and subversive of good medical treatment that it calls for action now by all responsible parties to put an end to it.[86]

- The Nader Task Force testified:

> In perhaps 50 percent of the letters we received there was a mention of patients being put under sedation for no other reason than simply to keep them quiet.[87]

VII. OTHER HAZARDS TO LIFE AND LIMB

Many other hazards exist in nursing homes. Perhaps the greatest is the possibility of death by fire. This problem is examined in Supporting Paper No. 5. Other hazards are caused by poor housekeeping and maintenance, exposing patients to infectious diseases, and housing patients in basements or attics in violation of law and regulations. Examples follow:

- A Detroit nursing home was barred from participation in Medicare partly because it had "no elevator even though blind, non-

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[83] Page 2335, part 19B, hearings cited in footnote 1.
[84] Report of Anthony B. Kist, Chief Section of Standards Compliance, licensing and Certification Programs, Division of Hospital Services, Minnesota Department of Health, March 8, 1973.
[85] Page 2335, part 19B, hearings cited in footnote 1.
[86] Page 1428, part 15, hearings cited in footnote 1.
[87] Page 883, part 11, hearings cited in footnote 1. See also part 19B, hearings cited in footnote 1 for the following examples: Abramson, 2234; Finney, 2246–48, 2253–55; Fox, 2258; Lace, 2309; Lehman, 2314; Meyer, 2323; McGillivray, 2330, Shypulski, 2338; Van Dyke, 2349.

ambulatory, or physically handicapped persons were housed above street level." Moreover, "the laundry was not separate from the boiler and incinerator room; its ventilation to the kitchen area is not adequate to prevent the spread of communicable diseases; mechanical ventilation to the kitchen is not adequate for communicable disease control." [88]

- The Minnesota Department of Health confirmed complaints from relatives that patients were being disturbed by ambulatory alcoholics. The nursing home in which they resided also was a State-certified detoxification unit.[89]
- Bureau of Health Insurance decertified an Ohio nursing home in part because:

  The kitchen personnel work in the laundry room until 3 p.m. and immediately follow this by working in the kitchen from 3:00–6:30 p.m. This would lead to cross-infection because of cross-contamination of the food preparation area.[90]

- An Illinois nursing home was expelled from Medicare because it did not have a current license and:

  The soiled linen room is used to store outer garments of the housekeeping staff and also is equipped with a table and chairs for the help to use at coffee breaks; a very unsanitary practice.[91]

- An Ohio nursing home was decertified because the home was "not constructed, equipped, or maintained to insure the safety of patients." There was no nurse call system; no sprinklers in hazardous areas; the electrical and mechanical systems of the home were inadequate and not maintained in accordance with recognized safety standards.[92]
- The Wisconsin Health Department cited one nursing home 5 straight years for failure to require its employees to take physical exams in accordance with law and for purposes of disease control. At one time 111 employees were serving without such physicals. Moreover, even though State law bars admission of patients with contagious disease, the home admitted a patient "with the diagnosis of Salmonella carrier", and isolation procedures had not been followed.

  In another case, a patient was being treated with a heat lamp for bedsores, but the treatment was not prescribed by a physician. Other medical tests and consultations were performed without physicians' orders.[93]

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[88] See report cited in footnote 81.

[89] Report of Anthony B. Kist, chief, section of standards compliance, licensing and certification programs, division of hospital services, Minnesota Department of Health, April 12, 1973.

[90] Report from Thomas M. Tierney, Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, September 28, 1971, to Curtis Nursing Home, Inc., Cleveland, Ohio, in subcommittee files.

[91] Report from Thomas M. Tierney, Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, September 28, 1971, to Brentwood Nursing and Convalescent Home, Oak Lawn, Ill., in subcommittee files.

[92] Report from Thomas M. Tierney, Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, September 27, 1971, to Avon Convalescent Center, Cincinnati, Ohio, in subcommittee files.

[93] Report from George H. Handy, M.D., State health officer, Wisconsin Department of Health and Social Services, to Mr. Lawrence Cotton of the Mount Carmel Care Center, Milwaukee, Wis., February 16, 1973, in subcommittee files.

• The following examples were taken from sworn statements received at the subcommittee's Minnesota hearings:

One day we found out from Mrs. Bunn that another patient . . . had gone to the hospital and had died. But we found out from Mrs. Bunn that he had died of tuberculosis. He died at Midway Hospital. We asked Mrs. Bunn where she heard about this. She told us that she had overheard . . . [the head nurse] and the doctor talking about it in the hall. The Administration never told any of us about this patient dying of tuberculosis. We didn't find out until two weeks later and that was by accident. We double checked with one of the nurses on duty, and she confirmed it that Mr. . . . had died of tuberculosis. They never told us anything about it, and we had worked very closely with this patient, brushing his teeth for him and everything. There were also other patients that were in the same room with him before he went to the hospital. I went immediately downtown and got a Mantoux Test. We also talked to Mr. . . ., who was guardian and administrator for Mr. . . ., and he said, "Well, I thought they told you he had died of tuberculosis". They put another patient into the same room that Mr. . . . had left, and they never cleaned the room up. To the best of my knowledge they did not do any checks for TB on any of the other patients after the death of Mr. . . .[94]

* * * * *

Once before I left this home I complained to the fire marshal in Golden Valley. Sometime during the day he came out and looked the place over. He said that they had to unblock the door to the storage room in the basement. This door was blocked with suitcases, beds, and other stuff. Except for a stairway and elevator, this door to the storeroom was the only exit. There were no windows in the basement. If you were standing on the floor of the basement, the ground level would be above your head. There were three nonambulatory patients living in this basement when I worked there. One of them was a 19-year-old quadriplegic. A retarded aide and the janitor also lived in the basement. The fire marshal left a sheet of instructions of things to be done. None of them were ever done.[95]

* * * * *

If anything major went wrong with that building on a Saturday, they would always wait until Monday to get it fixed because otherwise they'd have to pay double. That floor is also a fire-trap. The doors on each end are locked, and the last place you'd want to go down in case of a fire would be an elevator. Very frequently the elevators would malfunction, too. They were often stuck. I don't know how we would have ever gotten out of that building if there had been a fire. There was no outside fire escape.

[94] Page 2293, part 19B, hearings cited in footnote 1.
[95] Page 2333, part 19B, hearings cited in footnote 1.

> They also have rats out at this home. They have a chute that goes up to the 3rd floor. In this chute you would put all of the trash that you had. Many times, especially on week-ends, the trash would fill all the way up that shaft to the 3rd floor so that you couldn't stuff any more things into it. All it would take would be one lighted cigarette to start that on fire. This was especially bad on week-ends. The trashmen did not come on week-ends. One day the trashman came in and told the medical aide on the 1st floor that he was not going to pick up the trash there any more unless [the administrator] got rid of the rats.[96]

VIII. UNAUTHORIZED OR IMPROPER USE OF RESTRAINTS

The subcommittee has received many complaints about the use of restraints. A restraint is any technique, device or drug which interferes with the free movement of a person and which cannot be easily removed by such person.[97] Restraints may be categorized as follows:

(1) Mechanical, an apparatus or device such as straps, straight jackets, or handcuffs;

(2) Manual (the use of attendants to grasp or hold a patient);

(3) Seclusion, physical separation from others, including isolation;

(4) Hydrotherapy, water treatment which usually involves hot or cold baths (continuous or not), wet sheets or cold packs; and

(5) Chemical, which includes drugs and sedatives to stimulate or suppress motor functions.

All types of restraints mentioned above have been used in nursing homes.[98] Almost all States require a physician's order before an individual can be restrained. Most State laws prohibit the use of some types of restraints and most require careful monitoring of patients. For example, Arizona, Idaho, Indiana, Pennsylvania, and Wisconsin require that restrained patients be checked every hour. Maine requires supervision every half hour. Alabama, Delaware, Illinois, Maryland, New Jersey, and Tennessee limit the use of restraints to 24 hours—a physician must review and revalidate restraint orders each day. Minnesota requires that a special attendant be on duty on each floor where a patient is restrained.[99]

Complaints about the use of physical restraints are fewer now than in previous years—perhaps because administrators feel that the use of drugs is a more appropriate way to restrain individuals. A full discussion of the use of drugs to restrain can be found in Supporting Paper No. 2. Most State statutes are silent on the use of drugs, therefore the practice, if ordered by a physician and with proper supervision by nurses, is legal. However, there is one caveat. At least 10 States have laws which require restraints to be removed for short in-

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[96] Page 2303, part 19B, hearings cited in footnote 1. See also: Henry, 2277; Marotz, 2318; Finney, 2256; Lace, 2310; Lang, 2311; Meyer, 2323–24; Schallberg, 2333; Stage, 2336; Shypulski, 2340–1; Van Dyke, 2347.

[97] Pages 17–18, chapter on Consent, in source cited in footnote 10.

[98] Pages 17–18, chapter on Consent, in source cited in footnote 10.

[99] Pages 17–18, chapter on Consent, in source cited in footnote 10.

tervals and a large number require that restraints be easily removed in the case of fire or emergency. Such laws could be interpreted to bar the use of drugs as restraints unless the effect of the drug could be quickly diminished in emergencies.[100] Indeed the subcommittee has received testimony that drugs have prevented the evacuation of patients in at least two fires.[101]

The subcommittee often receives letters from persons who complain that a relative is "tied like an animal" [102] hour after hour and sometimes without physician's orders.

Proper medical practice limits the use of restraints to two purposes; First, to control behavior when a patient is out of contact with reality and a danger to himself or others; and second, to prevent patients from falling out of beds, chairs, etc., or from contaminating wounds or tearing off dressings.

Even in this context, geriatricians like Dr. Michael B. Miller, Medical Director, White Plains Center for Nursing Care, assert:

> **To the educated person the use of restraints is an admission of failure of the nursing process.[103]**

Specific examples received by the subcommittee follow:

- Fire Chief Beman Biehl of Marietta, Ohio, testified that he and other rescuers had difficulty removing patients from a nursing home fire because they were tied to their beds. The fire, on January 9, 1970, claimed 32 lives.[104]
- An elderly Japanese woman was strapped to her wheel chair in a California nursing home "presumably for her own protection. She was unable to speak any English and no bilingual staff was present. She was ignored most of the time. One day she was found dead of suffocation because the straps were too tight." [105]
- Illinois Health Department files note one instance where inspectors reported seeing one patient trying to go to the bathroom with a chair still tied to him with restraints. Other patients were found tied to chairs.[106]
- One witness testified:

> A woman in a Minneapolis suburb remembers with vivid pain what happened when she took her mother, who had suffered a stroke, to a nursing home and returned the next morning to find her tied, without clothes, in bed in the midst of her own wastes. "I will never forget that sight," the woman wrote. "It's seared into my memory, seeing her struggling to free herself, crying out for someone to help her. She clung to me and cried like a child over and over again, 'Thank God you've come, thank God you've come.' " [107]

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[100] Page 21, chapter on Consent, in source cited in footnote 10.
[101] Page 380, part 4 and page 1751, part 16, hearings cited in footnote 1.
[102] Letter to Senator John V. Tunney from T. V., October 10, 1972 in subcommittee files.
[103] Page 308, part 3, hearings cited in footnote 1.
[104] Pages 370 and 403, part 4, hearings cited in footnote 1.
[105] Page 2474, part 20, hearings cited in footnote 1.
[106] Page 1016, part 12, hearings cited in footnote 1.
[107] Page 779, part 9, hearings cited in footnote 1.

She added:

> We had testimony given to us of an aged blind man, somewhat feeble but able to get around, strapped in a chair in front of a television set, supposedly for recreational purposes. He was sitting in his own excrement and crying with embarrassment. There was no reason for this. The man was not incontinent but was strapped in to avoid him "wandering around and getting in the way." With adequate orientation, and a little time spent, he could have made his own way to the toilet facility.[108]

- During the Florida hearings the subcommittee received a statement comparing today's restraints with "instruments of torture used during the 16th century." It said:

> The chain of that period had a leather cover over an iron chain and secured with pad locks. There are counterparts of this innovation of chain even having some refinement by being manufactured by using a canvas base. The use of a modified straitjacket; without sleeves; also a trade named device called "Posey" belt are in common use in most nursing homes on confused residents.
>
> There is to my knowledge no city in this fine country where it is permissible to injure, torture, practice cruelty, use a short rope or chain on any animal. Yet human beings who are in advanced years have to endure the cruelty of man because the proper care of such individuals requires extra help to service the needs of each.
>
> Senator Moss, please take the first small step and visit, without fanfare, some nursing home where the practice of chaining unfortunates is a daily chore. You will witness first hand how through the use of drugs these confused patients are sitting in a 75 to 85 lb. chair with a locked chain around the waist. These folks are real zombies, they do not know or think or complain. The chain is in use for the greater part of the 24 hour day; in bed or chair except when necessary for human waste.
>
> May I describe these torture chains in the eye of a mechanic by points of manufacture and breaking point of the bond; also how much weight dropped will separate the material.
>
> The first is a modified straitjacket manufactured without sleeves. This jacket is made from durable nylon cloth into which is incorporated several strands of ¼" nylon cord which is braided. These ropes have a fixed non-slip steel lock which when tightly drawn requires a 40 to 50 lb. pull to open. The breaking point on the braided ¼" nylon rope will test a weight of 150 lbs. on a 4 ft. drop.[109]

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[108] Page 779, part 9, hearings cited in footnote 1.
[109] Page 240, part 2, hearings cited in footnote 1.

The subcommittee's Minnesota hearings produced these examples:

- One aide testified:

  We have only two people who need to be constantly restrained in geriatric chairs all day. The amount of time they are under restraint is not logged.[110]

- A licensed practical nurse testified:

  The biggest problem we had at this home was that my mother was being tied up in a chair from early in the morning (probably around 7:00 a.m.) until 7:00 p.m. She was just left to sit there. She was not taken to the bathroom. My mother was ambulatory at the time, but the continued lack of exercise was making her condition worse so that it was becoming harder for her to walk. My mother had heart problems; she was confused; but she was in good health. They simply did not have time to watch her, and it was easier for them to tie her up. They said they tied her up because she was getting into things, and they were afraid she would fall. But that did not excuse their not taking her to the bathroom or giving her exercise. My niece. . . ., would go down to see her at noon every day and untie her, and take her to the bathroom. I would go down every night (40 miles round trip), and I would untie her and take her to the bathroom. I would walk her around a little bit and put her to bed.[111]

IX. REPRISALS AGAINST THOSE WHO COMPLAIN

The subcommittee received many examples of complaints to authorities which resulted not in correction of the deficiencies but in reprisals against the complainants.

- Typical of the letters received are the following:

  I hope you will come and visit me. Pretend you are a distant relative. I would talk on the phone but the walls have ears. I am in a hurry because I am typing this in OT [occupational therapy] and I would hate to think what would happen to me if the home found out what I am doing.[112]

  * * * * *

  Nurses yell, scold, and slap these patients. . . . Patients sit by the month . . . because no one has time to walk them down the halls. I swear to God the above are true. I can't sign my name because of retaliation to my relative.[113]

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[110] Page 2309, part 19B, hearings cited in footnote 1.

[111] Page 2281, part 19B, hearings cited in footnote 1. For further examples from part 19B, See: Biller, 2235; Bozych 2237; Eyford, 2245; Gardas, 2267; Hurwitz, 2281; Johnson, G., 2287; Jones, 2290; Kleppinger, 2307; Lace, 2309; Shypulski, 2339; Tretheway, 2345.

[112] Letter from J. B. of Minneapolis, Minnesota, in subcommittee files.

[113] Letter to Senator Frank Moss (anonymous) from Sonoma, Calif., October 14, 1971.

Some of the patients have been beaten and slapped around; nurses aides who intimidate patients so much that the patient cringes in fear when the aides pass them. . . . They even have their own informers, patients like ourselves, and who get special favors, so if you complain they really make it rough for you.[114]

- The relative of a patient who died in the Baltimore Salmonella epidemic wrote of the home's shortcomings, adding: "My mother never allowed us to report any of these conditions to the office for fear of having the aides completely neglect her on any other possible emergencies." She was actually told this by some of the aides.[115]
- The following additional examples are sworn testimony taken from the subcommittee's Minnesota hearings:

I do know that I was made to feel an interfering nuisance by the staff of the nursing home. Whenever I tried to intercede on my mother's behalf, no matter what reasonable request I made to try to help alleviate some of her suffering, it was totally ignored. If anything, it only seemed to make the staff treat her with more coldness and neglect.

I will never forget my mother, a gentle loving woman, kissing the hands of the staff who mistreated her, as though she were begging for some kindness and compassion from them.[116]

* * * * *

I complained to the head nurse about the other meals. Because I complained, the head nurse stopped helping my mother with the noon meals. So no one was feeding my mother. That's the way they handle things in nursing homes, if you complain about one thing, they just make it worse for you.[117]

* * * * *

I was always afraid to say anything or complain about the home for fear of what might happen to my brother. I found myself lying about the home in front of their staff. I would tell them what a wonderful home they had and what wonderful care they gave their patients, though that was a lie, but I felt I had to lie for my brother's sake.[118]

- A 62 year old patient in a New York nursing home suffered a cardiovascular accident (CVA) and was, therefore, paralyzed on one side. A tray of food, containing his lunch, had been placed near his bed at about 11:20 a.m. The patient, in attempting to reach his food, fell off the bed and onto the tray. Though he called for help, no one came to him. At approximately 2:15 p.m., members of his family came to visit him and found him still on

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[114] Letter to Senator Frank Moss (anonymous) from Philadelphia, Pa., August 19, 1974.
[115] See letter cited in footnote 39.
[116] Page 2234, part 19B, hearings cited in footnote 1.
[117] Page 2281, part 19B, hearings cited in footnote 1.
[118] Page 2273, part 19B, hearings cited in footnote 1.

the floor. Outraged, they complained to the management. The next day, the family was told he was a "management" problem and that they would have to relocate him within the next 24 hours. The family did so. Patient died that week.[119]

Fear of reprisal undoubtedly prevents many complaints from being aired. Fear can also affect nursing home personnel. Nursing home employees have lost their employment because of their testimony to the subcommittee or State Health Departments.[120]

X. LACK OF EYE CARE, DENTAL CARE, AND PODIATRY

A serious gap in quality nursing home care exists with respect to eye care, dental care, and podiatry. Nursing home patients urgently need such services but seldom receive them.

A. THE NEED FOR EYE CARE

Nursing home patients rarely can expect any sort of eye care, according to information presented to the subcommittee. As a result, their already limited vision may deteriorate.

The "Joint Study of Vision Problems of South Dakota Nursing Home Residents" was presented to the subcommittee in 1973. This joint effort by the Lion's Sight and Service Foundation, the South Dakota Optometric Association, the South Dakota Association for the Blind, the Governors' Advisory Council on Aging, and the South Dakota Service to the Visually Impaired, produced dramatic findings.[121]

Of 4,389 patients tested, results were obtained for 3,805. (Nonresponse in the other cases was commonly attributed to "senility," or language barriers.) Of the 3,805 sample, 676 were legally blind and another 602 were in the low-vision category. The study showed that blindness increases with age. Perhaps most significant is that 67 percent of those legally blind and 66 percent of those in the low-vision category could have had their opacities removed and the blindness prevented. Even more damaging was the disclosure that 67 percent of these individuals were eligible for eye care under the South Dakota Medicaid program, thus, the reason that blindness was not prevented was more a reflection of a lack of care and concern than the inability to pay for the preventive techniques.

Another serious problem is that eyeglasses of patients are often lost or misplaced. Personnel at one nursing home testified about having their own "optical shop."

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[119] See letter cited in footnote 17.

[120] Pages 2381–82, part 19B, hearings cited in footnote 1, for resolution by Minnesota Nursing Home Association against "blackballing" employees who testify before the Senate subcommittee and for letters of dismissal sent to employees Krueger and Marotz on December 6, 1971, 7 days after their appearance before the Moss subcommittee. The nursing home operator contended that the dismissals were for cause, and that the timing was merely coincidental. See also page 2099, part 19A, hearings cited in footnote 1, where an orderly reported receiving threatening calls the night before he testified. Following the hearing, he reported an attempted stabbing. Senators Mondale and Moss wrote to FBI Director J. Edgar Hoover asking for an investigation. The orderly suffered only minor injury in the alleged altercation and no assailant was ever brought to justice. See part 19B, page 2426 for exchange of letters.

[121] Report dated February 12, 1973, in Subcommittee files.

> You can see over there [indicating], we have eyeglasses, and these are eyeglasses that are misplaced. Like they will take a patient's eyeglasses off at night and then when we come the next day they are gone, and they get thrown in a box in a room and, because we don't remember what their eyeglasses look like and they aren't marked, we can't put them back on. Now and then we will gather the staff around and try to put glasses on patients.[122]

Many progressive nursing homes sidestep this problem by marking patients eyeglasses with their names attached by means of inexpensive plastic embossing.

B. PODIATRY NEGLECTED

The subcommittee has also received evidence suggesting that nursing home residents need more attention to foot care. The aides and orderlies who are charged with doing this work told the subcommittee that they had too much to do and not enough time to attend to the podiatry needs of patients. The lack of podiatry was singled out in the Nader Task Force Report as a significant problem.[123] Following are some excerpts from subcommittee testimony:

> There was another woman at the home that always walked around barefoot. She had palsy and I asked her why she walked around barefoot since it was so cold. She told me she couldn't put shoes on because they hurt her feet too much because no one would cut her toenails. Many people there seemed to have trouble with their toenails. Twice while I was there I saw this woman with the bad toenails fall and hurt herself badly. At least once she had to be taken to the hospital because of these falls.[124]

* * * * *

> Toenails and fingernails were never cut during my shift. They were supposed to be cut right after their bath, but the baths were not given on our shift. Many times the toenails got so long that they grew around and grew into the toes underneath. The toenails of the majority of patients on the second floor were in that condition. I would say that approximately twenty-five patients had this condition.[125]

* * * * *

> We had a terrible problem with the toenails of the patients at this home. It is charted for the aides and orderlies in the morning when they give the baths to the patients that they are supposed to trim all of the toenails after the bath. The chart says, "Cut their toenails and comb their hair after their bath". One day I noticed a woman by the name of . . . walking down the hall and she seemed to be in pain because her feet hurt. This . . . had toenails that were so long they were curved

[122] Page 2133, part 19A, hearings cited in footnote 1.
[123] Page 880, part 11, hearings cited in footnote 1.
[124] Page 2106, part 19A, hearings cited in footnote 1.
[125] Page 2277, part 19B, hearings cited in footnote 1.

around and coming back underneath her toes and digging into the bottoms of her toes. So we decided that we should check some of the other patients, and we found that at least a dozen patients had the same problem with their toenails.[126]

C. THE LACK OF DENTAL CARE

A common assumption is that all nursing home residents have dentures and little need for dental services. Accordingly, few nursing home residents ever receive dental *examinations*. Studies and direct evidence received by the subcommittee, however, indicate that patients have substantial dental problems.

The Harvard School of Dental Medicine, for example, reports that 77 percent of the patients in its study of nursing home residents had not seen a dentist since entry into a nursing home.[127]

A second study indicated that 54 out of 74 residents (78 percent) in one nursing home needed dental care, including extractions, restorations, and treatment of tumors.

A third study of three nursing homes indicated that 64 percent of the 188 patients examined needed professional dental care.

These survey results are confirmed by direct testimony:

- A patient in a New York nursing home asked the subcommittee to investigate the home because "These sick people were left hopeless and in pain for the wanted attention. Even today men are complaining of toothaches and swollen jaws for want of a dentist." [128]
- The Medicare inspection records for a Wisconsin nursing home report "most patients had new (never used) tooth brushes which were stored at the nursing station." [129]
- The same witnesses who testified that a particular home kept an "optical shop" (see above), also testified that the home kept a "dental shop" (a cardboard box full of misplaced dentures). They explained that this home had no dental care and no facilities for the care of dentures. Once the teeth were taken out they never were put back in. To save their teeth they never took out their dentures:

  In the treatment room we have a big box of dentures. When we can't find a patient's teeth, we just go into this box and get him some other ones.[130]

- One registered nurse told the subcommittee that one day she visited her mother in a nursing home and found that "she had someone else's teeth in her mouth." [131]
- The subcommittee's Minnesota hearing produced these examples:

  There was another patient on the third floor by the name of . . . . This patient was younger, about 50 or 55-years-old.

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[126] Page 2295, part 19B, hearings cited in footnote 1.
[127] Letter to Senator Moss and enclosures from Dr. Donald Giddon, professor and head of the Harvard School of Dental Medicine, in subcommittee files.
[128] Letter from O. M. of June 4, 1970, in subcommittee files.
[129] See source cited in footnote 79.
[130] Page 2340, part 19B, hearings cited in footnote 1.
[131] Page 2281, part 19B, hearings cited on footnote 1.

She was very intelligent, quite religious, and a very talkative person. She also was a stroke patient. She had one leg that was paralyzed. This patient's teeth were just caked green. I had asked many, many times for toothbrushes and toothpaste for the patients. I reported that her mouth was getting very green and that her breath smelled. The doctor finally came in and said that she had pyorrhea and ordered hydrogen peroxide to wash out her mouth. We washed out her mouth with this peroxide for a few days, and a few days later the same house doctor came in and asked which patients he should see. We told him why didn't he see Mrs. . . . because her mouth was not getting any better. He said "Well, she is a difficult patient, and there isn't anything we can do for her anyway." This patient was very talkative and complained all the time about a lot of things. One day we came to work and found out they had upped her dosage of Thorazine. Thorazine is a tranquilizer. They really upped it a large amount. We thought that they were trying to get her to shut up because she talked and complained too much.[132]

* * * * *

In the morning the patient's dentures were always put back in their mouths without being cleaned. I don't believe that the dentures were ever cleaned for these patients during the whole time that I was there. They were corroded.[133]

XI. ASSAULTS ON HUMAN DIGNITY

Another common complaint is that nursing home patients are treated like "objects" rather than as individuals in some nursing homes. A great many complaints were received claiming that patients were given showers or baths in very hot or cold water as punishment, others were left sitting in the bath "for hours with the door open." [134]

The following is a partial list of indignities suffered by some nursing home patients:

- The Nader Task Force reported that dead bodies remained in nursing homes for long periods of time, sometimes unscreened from other patients. For example, "This no-legged man died at 9 in the morning and they didn't remove his body until 11 *that night.*" [135]
- The Minnesota Department of Health confirmed that a dead patient, although screened from others, lay in a 3-bed room all night.[136]
- In another case, inspectors verified a complaint by a cook at the nursing home who complained that she was asked to take care of a dying patient. She claimed that she had no experience, and the patient should have been transferred to a hospital.[137]

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[132] Page 2293, part 19B, hearings cited in footnote 1.
[133] Page 2105, part 19A, hearings cited in footnote 1.
[134] Letter from J. R. G. of July 25, 1970, in subcommittee files.
[135] Page 880, part 11, hearings cited in footnote 1.
[136] See report cited in footnote 84.
[137] Report of Anthony B. Kist, chief standards compliance section, division of hospital services, Minnesota Department of Health, April 23, 1973.

- The Minnesota Health Department also documented cases where mentally disturbed patients were mixed with the same patients who were physically ill. The former exhibited bizarre behavior patterns frightening the physically ill patients.[138] Two other witnesses provided similar testimony:

> The judgment as to what patients are put together is based on whatever room they've got available and they can get the most money out of. They don't consider the mental state of the patients.[139]
>
> * * * * *
>
> They had a roommate in with my sister who was a little confused and always upset. For example, one day my sister went over to move the window up a little bit and her roommate got her very upset and even went over and bit my sister on the arm. They finally got her out of my sister's room. I don't think they should mix up people who have a normal state of mind with those who don't.[140]

- A Utah administrator testified:

> Self respect is destroyed when a patient is restricted to a regimen of a bath *once* a week—whether the patient *needs* it or not—*IF* it is convenient. Some of the patients who came to . . . [our nursing home] had dirt accumulated in the hair so that the scalp had to be soaked to soften the dirt and then the dirt would be scraped and crumbled by the fingers so that it could be removed without pulling the hair out by the roots. Putrid excreta would be so matted into the pubic hair and between the buttocks that it would have to be soaked repeatedly in soap and water before it could be dislodged with wash cloths and scrubbing brushes. Care had to be taken to prevent damage to the corroded flesh.
>
> The patient is ashamed of his inability to maintain bowel and bladder control. His feelings of guilt and self-disrespect are increased when soiled clothing and bedding must be endured for long periods of time. Employees of the facility frequently scold and ridicule patients when accidents occur but do little toward scheduling training and control. When visitors come, their reactions to the strong odors are obvious to the patient. This barrier to enjoyable social experiences exists for long periods of time for both patient and visitors.[141]

- The Wisconsin Health Department confirmed that baths in one home were not given for periods up to 3 weeks. One patient had only two paths in his 10 weeks at the home.[142]

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[138] See report cited in footnote 84: also report on Trevilla of Robbinsdale provided by Dr. Warren R. Lawson, secretary and executive officer, Minnesota Department of Health, March 29, 1972.
[139] Page 2320, part 19B, hearings cited in footnote 1.
[140] Page 2265, part 19B, hearings cited in footnote 1.
[141] Page 572, part 7, hearings cited in footnote 1.
[142] See report cited in footnote 93.

• The Minnesota hearings produced these examples:

Many of the seniors got embarrassed when we have to call maintenance men to help female patients into the bath. We put a gown over them when they get up, but they still get embarrassed. The other thing is that the maintenance men don't know how to handle the people well. They don't have any sensitivity towards the patients. They rush in and pull the patient out and scare them to death. This happens constantly. The personal modesty and privacy of the patient is not emphasized. Many rooms don't have screens. Even if there is a screen in the room, it isn't necessarily used.[143]

* * * * *

My mother was forced to stay in a room over my protests with a terminal cancer patient and the stench in the room was unbearable, partially due to the fact that the patient was not kept clean.[144]

* * * * *

One day when I was there an old man who was about 90 years old went into one of the ladies' rooms by mistake. As a result of this mistake by this man, he was ridiculed and laughed at by many of the staff of the home. This same old man never had any underwear on. The home was hard up for underclothes, I guess. He had a big pair of trousers on that he wrapped around his waistline. He had trouble getting to the bathroom, and once he had a bowel movement accident while he was trying to get to the bathroom. This bowel movement rolled out of his pants and onto the floor. He tried to put it over into a corner with his shoe. Of course it got all over his shoe and everyone else was stepping in it. Nobody bothered to come and clean it up. Everybody would wait for somebody else to clean it up.[145]

* * * * *

There is also a pathetic shortage of clothes for the patients. It gets so bad that I have come on to work at 3 o'clock and their pants are held together, they are too small and the fly on their pants are held together, by a chain of pins because they are so small.

Also the linen in this home, they have the first floor, it is called the show floor. They take, the laundry people in the laundry, divide the linen. The better linen goes to the first floor, then the next in line goes to the second. Then all the rags and the raveled and stained linen goes to the third floor where the senile patients are.[145a]

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• A reporter for a Long Beach, Calif., newspaper who worked in nearby nursing homes reported:

I watched an experienced afternoon aide coax a woman into bed at 6 p.m., so "I can get her out of the way for the night."

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[143] Page 2113, part 19A, hearings cited in footnote 1.
[144] Page 2234, part 19B, hearings cited in footnote 1.
[145] Page 2289, part 19B, hearings cited in footnote 1.
[145a] Page 2124, part 19A, hearings cited in footnote 1.

Her method: "Your son is gonna come and get you in the morning and take you home so you'll need a good night's sleep." [146]

- Similarly the Wisconsin Department of Health reported:

  Several patients in one home were put to bed with the room lights out at 1 p.m. Nurses told inspectors that patients were put to bed for a rest and that they would be helped out of bed in time for dinner. An inspector visited these patients again at dinner time (5:15 p.m.) and found they were still in bed.[147]

- The June 22, 1973 Medicare inspection of the Wisconsin home notes that on three dates, May 5, 6, and 14 "patients in the men's wing were not helped out of bed the entire day because of insufficient help." [148]

XII. PROFITEERING AND "CHEATING THE SYSTEM"

The subcommittee received far fewer examples, comparatively, of profiteering and abuse of the system than it received of patient abuse. While the topic of nursing home profits is discussed in Supporting Paper No. 9 a great variety of abuses fall under the related heading of profiteering.

Profiteering refers to the operator's claiming an unreasonable profit at the expense of his patients. The high demand for beds in some segments of the industry allows operators considerable latitude in setting their own prices for private paying patients.

Moreover, State public assistance payments to nursing homes often give the operator a flat fee—perhaps $14 a day per patient. Inevitably such rates, even in so-called "reasonable cost reimbursement" States, include built-in maximums which cannot be exceeded. Therefore there is little opportunity to increase profits by offering a superior product (better care) and the only practical way to increase profits is to reduce expenses.

Cutting expenses to the point of harming patients is attributed to many operators in sworn testimony received by the subcommittee. This testimony relates to operators who cut back on staff, spend as little as 37 cents per patient per day for food, weigh meat on a stamp scale, serve "mock meatloaf" or breakfasts of one half a slice of bread and coffee, and refuse to buy toothbrushes, toothpaste, toilet paper or other necessities.

There are other ways of cutting cost, such as keeping the heat down in winter and the air conditioning off in summer, using small wattage

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[146] *Long Beach Independent and Press Telegram,* "Convalescent Homes—Havens or Hells?", by Barbara Fryer, May 17, 1970, p. A1.

[147] See footnote 93.

[148] See report cited in footnote 79. See also part 19B, hearings cited in footnote 1: Abramson, 2231, 2233; Finney, 2248, 2250–51; Fox, 2260–61; Grew, 2266; Gruss, 2269; Harms, 2271; Henry, 2277, 2280; Hurwitz, 2284, 2287; Johnson, J., 2289; Kleppinger, 2305–07; Lace, 2310; Marotz, 2318; Meyer, 2224–25; Moriority, 2325; McGillvray, 2328; Nepenin, 2331; Shypulski, 2340; Tenney, 2343; Tretheway, 2345.

bulbs or not replacing burned out bulbs, and postponing repairs and maintenance. There is virtually no end to the variety of "cost-saving" examples used by some nursing homes.

- Examples presented to the subcommittee in sworn statements from nursing home personnel include:

> The administrator, Louis Thayer, doled out liquid soap an ounce at a time. . . . They rationed toilet paper and we had nothing to clean out bathtubs with. Mr. Thayer told us that Dutch Cleanser was against regulations.[149]
>
> * * * * *
>
> They told me I would have to get somebody else's bedpan because they didn't have one for me. . . . There was also no table next to my bed so that I could keep a glass of water and my eyeglasses there. The home just did not have enough equipment. That same night I wanted to wash my face and hands, so I asked for a pan and some towels. They told me I couldn't wash my hands because they didn't have any towels.[150]
>
> * * * * *
>
> They reuse catheters at this home. They are supposedly cleaned and sterilized when they have been given to me to insert. However, I have found catheters that had sediment inside of them. Even though they reuse the catheters, they still charge the patients for the cost of a new one. Relatives have asked me why they are charged for a new catheter and I have to tell them that I have not used a new catheter but have put in a used one. . . . I am hired as an orderly but I also end up being a maintenance man, a janitor, and did general clean-up. I want to know why I am asked to carry down the garbage, to repair broken down articles, to scrub the dayroom and clean up urination in the hallways. It seems to me that they should have efficient maintenance men so that I can take care of the patients.[151]
>
> * * * * *
>
> In the winter this home is very cold. . . . I had to put coats over the doors and blankets around the cracks in the windows. They keep the thermostat locked up. I had a key for it. I would go and turn it up. However, next time I came back it was turned down again . . . at times as low as 69° or 65°.[152]

Other examples of profiteering concerned the use of "ancillary charges." In other words, private paying patients are charged extra for services and supplies. The following schedule of ancillary or additional charges was printed in the Congressional Record by former Congressman David Pryor.*

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*In November 1974, Mr. Pryor became Governor-elect of Arkansas.

[149] Page 2292, part 19B, hearings cited in footnote 1.
[150] Page 2269, part 19B, hearings cited in footnote 1.
[151] Page 2318, part 19B, hearings cited in footnote 1.
[152] Page 2244, part 19B, hearings cited in footnote 1.

"ADDITIONAL CHARGES"

For a Nursing Home in Northern Virginia

(It should be noted that these are charges in addition to the $595 (single room) per month cost)

Admission sets		$3.50
Air mattress	per month	45.00
Air worms		3.50
Alcohol	per pint	.50
Aspirator	per day or use	5.00
Baby oil		1.00
Bed sore care	per day	3.00
Bibs, plastic		2.50
Bladder irrigation tray		1.50
Body lotion		1.00
Catheters (Foley)		3.50
Catheterization sets		2.00
Chest restraints		10.00
Denture cups		.25
Diabetic diet	per month	15.00
Disposable Chux	each	.15
Drainage bags and tubing for catheterization sets		1.00
Emesis basin		1.50
Enemas: Fleet/oil		1.00
Foam cushion or ring		4.85
Guest trays:		
Luncheon or breakfast		1.00
Evening meal		1.50
Hand feeding	per month	45.00
Hand restraints		3.00
Hypodermyclysis sets		2.00
Intravenous sets		2.00
Incontinent care (including Chux)	per month	80.00
Intensive nursing care—terrace floor	per month	90.00
Irrigation set		1.50
Levine tubes		2.00
Liter cytol urologic irrigating fluid	per liter	2.50
Medicated powder		1.40
Nasal catheters		1.00
Oxygen:		
One-fourth tank or less		10.00
One-half tank		15.00
Oxygen mask		1.00
Personal laundry	per month	10.00
Plastic gloves		.10
Posey restraints		6.00
Rectal tubes		1.00
Restraining chair		N/C
Shampoo	per pint	1.00
Sheepskin (synthetic)		10.00
Solutions for clysis and I. V.'s	per bottle	5.00
Spray deoderant		1.30
Suction machine	per month	25.00
Suction tube		.50
Television in room	per room	21.00
Tissues		.25
Trapeze	per month	15.00
Tube feeding		30.00
Rubber pants		5.00
Walkers		3.00
Wheel chairs	per month	15.00
Senile care	per month	90.00
Syringes		1.00

Mr. Pryor also noted that some individuals may be misled into thinking the basic rate of $595 a month is all-inclusive. He charged nursing homes did not spell out all the extra charges that they included in patients bills.

He said:

> I would call your attention to the item "Air mattress, $45 per month." How many times over would a bedridden patient pay for this product?
>
> Here's another: "Bed sore care, $3 per day." This could well add $90 a month to a patient's bill.
>
> Here is "Hand feeding, $45 a month." Is this an honest "additional charge" for a bedridden patient who may be unable to feed himself?
>
> On the surface, this particular home bills its patients a reasonable fee—$595 per month for a private room—but the "extra charges" above could quickly bankrupt an unsuspecting son, daughter or patient.[153]

Newspapers from time to time report that nursing home operators have added charges above the rate paid to the home by the State Medicaid program. Charges in excess of Medicaid payments are a clear violation of the law in all but four Southern States.[154]

These usually illegal charges may be in the form of cash, "under-the-table" payments to the operator, undisclosed to the State or the Internal Revenue Service. A more subtle variation requires the family to make a "gift" or "donation" as a precondition of the nursing home's acceptance of a Medicaid patient.

In Jacksonville, Fla., one administrator required the children of a patient to sign a contract, conditionally accepting their mother, provided they paid an $8,500 "gift" in addition to the $900 a month for her care in the nursing home. If the children did not permanently retain the mother in the nonprofit facility they were required by the terms of the agreement to pay "a $1,000 pledge" to the nursing home.[155]

Some nursing home operators justify these practices on the grounds that they lose money on Medicaid patients because rates paid by the States are too low.

Some nursing homes flatly refuse to take Medicaid patients. In San Francisco, for example, nursing home beds are available, but only to private paying patients. Medicaid (called Medi-Cal in California) must usually transfer patients from 50 to 100 miles away from their home in San Francisco to find a home willing to take them.[156]

In California hearings, one witness said:

> . . . a horrifying statistic for San Francisco is that over half of our elderly citizens who need placement in long-term facilities are placed out of their city, as far away, some of them, as far away as San Bernardino County, to the south,

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[153] Congressional Record, February 24, 1970, p. H1215.
[154] *New York Times*, November 11, 1972.
[155] Duplicated copy of contract dated July 10, 1969, in subcommittee files.
[156] Pages 490, 495, 502, and 503, part 6, hearings cited in footnote 1.

and Humboldt, to the north. which is almost at the Oregon border. There is no need to tell you what this does to relationships, to two persons who have been married for say, 50 years, and other relatives and friends who cannot visit the elderly patient.

Another said:

> . . . for over a year not one Medi-Cal beneficiary needing long-term care has been placed in a private San Francisco nursing home. Moreover, the agency reports that the pressure created by the placing of San Francisco residents out of the county is beginning to lead to a shortage of Medi-Cal long-term beds in San Mateo County as well.[157]

Some nursing homes may not refuse "welfare" patients, but provide inferior care for them. Mr. Walter Adams, president of the Connecticut chapter of the National Council of Senior Citizens told the subcommittee:

> There are some convalescent hospitals that have three services; namely a private section, another for Medicare patients, and a third for welfare patients. There are three types of meals; one for private patients, a second for Medicare patients and a third type of meal for welfare patients.[158]

On the other hand, some nursing homes accept only welfare patients, and they show great profits. Older homes with smaller mortgages, low interest, or no mortgage have a competitive advantage.

One operator collected $400,000 in 1970 from Medicaid (welfare) showing a profit of $185,000.[159] Clearly, the economics of the system work to perpetuate rundown or at least older facilities.

A final method of profiteering is outright fraud such as offering or accepting "kickbacks," collecting duplicate payments from Medicare and Medicaid or collecting money for patients that have died or been discharged. Present data suggests that "kickbacks" are widespread between nursing home suppliers (particularly pharmacists [160]) and the nursing home. This topic is discussed in more detail in Supporting Paper No. 2.

The U.S. General Accounting Office has continued to monitor duplicate payments and collection after death. In one audit of Medicaid nursing homes in California, GAO discovered that:

> . . . in some cases, care was approved for periods after the date of death or discharge of the patients.
>
> . . . in 22 of 260 cases examined, claims were paid for periods after a recipient had died or had been discharged from the nursing home.
>
> . . . in 12 of 76 additional cases examined, nursing homes were receiving full payments under both the Medicare and

[157] Pages 490, 495, 502, and 503, part 6, hearings cited in footnote 1.
[158] Page 301, part 3, hearings cited in footnote 1.
[159] Page 1256, part 13, hearings cited in footnote 1.
[160] Speech by Senator Frank Moss to the American Society of Consultant Pharmacists, October 1, 1972.

Medicaid programs for the same days of nursing home care.

In view of the weaknesses in procedures and practices and the high incidence of questionable payments (34 of 336 cases examined), GAO believes that the results of its review sufficiently demonstrated the need for corrective measures to strengthen controls over the approval and payment for nursing home care.

In calendar year 1968, about 100,000 Medicaid recipients received nursing home care in California in about 1,250 nursing homes and, in view of the costs of the program, the lack of adequate control over the approval and payment for nursing home care can result in significantly increased program costs.[161]

As the GAO noted, the program is deficient in relying on providers to notify HEW of duplicate payments. The GAO also noted that most duplicate payments and payments after the death of patients were eventually recovered. But even when such payments are recovered the operator's use of the money constitutes an interest free loan which can be used as operating revenue.

[161] Date of audit is July 23, 1970, reprinted in *"Developments in Aging, 1970,"* report of the Special Committee on Aging, Washington, D.C., March 24, Leg. Day, March 23, 1971, p. 46.

PART 2

HOW MANY NURSING HOMES ARE SUBSTANDARD?

The obvious question from the foregoing examples is: How many nursing homes have such problems? How many are substandard?

In attempting to answer this question the subcommittee has employed objective criteria matching the nursing homes' performance against accepted State or Federal standards. It was assumed that if such laws and standards were followed, the well-being of the patient would result. However, there are so many applicable standards that it is conceivable that each and every nursing home in the Nation violates some regulation.

The appropriate question is, therefore, how many nursing homes have serious and life-threatening (as opposed to technical) violations? Applying this analysis and on the weight of the evidence, the subcommittee concludes that over 50 percent of the nursing homes in the United States are substandard.

Given present conditions and policy shortcomings, it could scarcely be otherwise. As stated in this subcommittee's Introductory Report, the United States has no consisent policy with respect to treatment of the infirm elderly. In addition, State public assistance formulas contain financial incentives which guarantee poor care; doctors avoid nursing homes; the enforcement system is not working; and 80 to 90 percent of patient care in nursing homes is being given by untrained aides and orderlies.

The inescapable result of the interaction of these factors is poor care and abuse of which the preceding examples are merely illustrative. Thousands of similar examples are contained in the subcommittee's hearings, in committee files, or in the files of State health departments. In the words of investigator Bill Hood, of Chicago's Better Government Association, *State health department files contain more horrors than can be imagined by the media or critics of the industry.*[162]

Support for the subcommittee's judgment that over 50 percent of U.S. nursing homes have substandard or life-threatening conditions can be found in many quarters.

First, supporting documentation can be found in the thousands of letters received by congressional committees and individual Members of Congress complaining of nursing home care. Many Senators and Representatives shared such items with the subcommittee, which upon investigation found most of the complaints to

[162] Page 1474, part 15, hearings cited in footnote 1.

be valid. The experience of HEW's ombudsman programs operating in five States adds credibility. Program directors investigated 1,196 individual complaints on nursing homes and found more than 80 percent of them to be justified.[163]

A second source of support is the more than 50 major newspaper exposés on nursing homes in the past 10 years.

The similarity of the charges against the facilities is noteworthy. The reliability of these exposés has been confirmed on several occasions by followup investigations conducted by State or Federal agencies. The *Chicago Tribune*,[164] *St. Petersburg Times* [165] and *Milwaukee Journal* [166] articles are notable examples.

A third source of support is found in the judgments and conclusions of experts.

Dr. J. Raymond Gladue, president of the American Association of Nursing Home Physicians, for example, testified in October 1973 that the quality of care in U.S. nursing homes was "either very poor or scandalous." He added that he has seen very little improvement in the past 5 years.[167] In his 1973 appearance before the Committee on Aging, Nelson Cruikshank, president of the National Council of Senior Citizens, described conditions in the Nation's nursing homes as "nothing short of a national scandal." [168] In 1971 the executive council of the AFL–CIO issued a statement protesting "the heartless indifference, cruelty, neglect, and financial exploitation in U.S. nursing homes." Bert Seidman, speaking for the AFL–CIO, charged that 4 out of 5 (80 percent) nursing homes are in violation of Federal and State standards." [169]

Independent studies provide a fourth source of support, such as the Nader Task Force report charging that "80 percent of the nursing homes receiving Federal tax dollars were substandard." [170]

Former Congressman Pryor concluded on the basis of his own study that 80 percent of U.S. homes had serious violations.[171] During the subcommittee's 1971 hearings in Minnesota (a leading State in health care delivery), Daphne Krause, executive director of the Minneapolis Age and Opportunity Center, concluded that 40 out of the 125 homes evaluated during her 6-year study (or about 30 percent) had serious violations.[172]

A fifth source of support is studies conducted by State governments.

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[163] See report of the Office of Nursing Home Affairs, January 24, 1973, reprinted in *Developments in Aging: 1973 and January–March 1974*, report of the Special Committee on Aging, Washington, D.C., May 13, 1974, pages 285–95, at p. 294.

[164] Series of Articles from *Chicago Tribune* beginning February 28, 1971, reprinted on pages 1137–59, part 12, hearings cited in footnote 1.

[165] Series of articles from *St. Petersburg Times* beginning on September 28, 1969, reprinted at pages 245–60, part 2, hearings cited in footnote 1.

[166] See source cited in footnote 40.

[167] Page 2782, part 22, hearings cited in footnote 1.

[168] "Future Directions in Social Security," part 2, hearings by the Special Committee on Aging, Washington, D.C., January 22, 1973, p. 149.

[169] *Bergen Sunday Record*, "Retirement and You," by Theodor Schuchat, November 22, 1970; also, resolution of the AFL–CIO of February 17, 1971 sent to Senators Moss and Williams, in subcommittee files.

[170] Page 878, part 11, hearings cited in footnote 1.

[171] *New York Times*, August 4, 1970.

[172] Page 2092, part 19A, hearings cited in footnote 1; see also *Minneapolis Tribune*, November 30, 1971, p. A1.

In 1971, the Better Government Association, which worked with the staff of the subcommittee in evaluating Illinois nursing homes and State inspection records, concluded that 50 percent of the State's homes had serious life-threatening deficiencies.[173] The city of Chicago admitted 45 percent were substandard.[174] The Cook County Department of Public Health verified the BGA's charge with respect to the 100 homes in its jurisdiction.[175] The Illinois Department of Health concurred with the BGA charge.[176] Similarly, the Lieutenant Governor of Wisconsin, in his 1971 report, charged that 51 of Milwaukee's 99 nursing homes had serious violations; 35 homes had violations so serious to merit immediate action to close them.[177] In Florida, State Senator Louis de La Parte, chairman of the joint ad hoc committee to investigate nursing homes, disclosed that "40 of the almost 100 nursing homes investigated did not meet basic requirements." [178] Similarly, a November 1973 study by the State of New York revealed that nearly two-thirds of New York City's 104 nursing homes had serious operating deficiencies.[179]

Studies by independent agencies are a sixth source of support. The findings of the Cost of Living Council are incorporated into Supporting Paper No. 9.

In 1971, the General Accounting Office (GAO) concluded that over 50 percent of the nursing homes surveyed in three States—Oklahoma, New York, and Michigan—did not meet minimum standards with respect to fire safety, nursing care, and physicians' services.[180] In November 1972, another GAO report stated: "The quality of care in U.S. nursing homes is still far too low." [181]

A seventh support is the findings and pronouncements from the executive branch, specifically HEW and the White House.

In his June 1971 speech, President Richard M. Nixon noted that "many U.S. nursing homes are little more than warehouses for the dying." [182] The President's words were amplified by Under Secretary John Veneman who appeared before the subcommittee in October 1971. When asked how many U.S. nursing homes are substandard and have serious violations, he responded:

> **The question is difficult to respond to. The sample taken by the GAO indicated roughly a 50 percent figure in the Medicaid institutions they investigated were not complying with standards established by the program. As I pointed out in my testimony, it will vary from State to State. You will find some States where the ratio will be higher.[183] (Emphasis supplied.)**

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[173] Page 1028, part 12, hearings cited in footnote 1.
[174] Page 1124, part 12, hearings cited in footnote 1.
[175] Pages 1037 and 1049, part 12, hearings cited in footnote 1.
[176] Page 1058, part 12, hearings cited in footnote 1.
[177] See report cited in footnote 9; see also *Milwaukee Journal,* December 17, 1971, p. A1.
[178] Page 171, part 2, hearings cited in footnote 1.
[179] *New York Times,* November 1, 1973, p. 47.
[180] *Problems in Providing Care to Medicaid Patients in Skilled Nursing Homes,* report of the U.S. General Accounting Office, May 28, 1971.
[181] *Study of Health Facilities Construction Costs,* report of the U.S. General Accounting Office, November 20, 1972, p. 69.
[182] Speech by President Nixon to American Association of Retired Persons—National Retired Teachers Association, Chicago, Ill., June 25, 1971.
[183] Page 1980, part 18, hearings cited in footnote 1.

Arthur Hess, Deputy Commissioner of the Social Security Administration, noted at the same hearing that of the 4,339 Medicare certified homes only 1,141 had no serious violations. In sum, 73 percent had such violations. His data indicated that the violations were protracted. From September 1968 through December 1971 at least 70 percent of the participating homes had serious operating deficiencies.[184]

Both subcommittee and HEW data confirm that little has changed since the President's statement in June 1971. With the help of experts, the subcommittee concluded that the Nixon nursing home reforms had a negligible effect on improving care. In January 1974, HEW announced that 59 percent of the Nation's 7,000 skilled nursing homes do not meet Federal minimum fire safety standards. The Director of the Office of Nursing Home Affairs, Dr. Faye Abdellah, charged that an even higher percentage of the Nation's 8,000 intermediate care facilities do not meet Federal minimum fire standards.[185]

On June 11, 1974, testimony before the Special Studies Subcommittee, Committee on Government Operations, U.S. House of Representatives, representatives for the U.S. General Accounting Office revealed the results of its 11-State sample of nursing homes. *GAO reported that 72 percent of the sampled nursing homes had one or more major fire safety deficiencies.*[186]

The January 1974 HEW data and the June 1974 GAO data strongly indicate that protection against fire hazards had, in fact, deteriorated since 1971, when GAO's three-State sample disclosed 50 percent of the homes sampled did not meet standards.

Obviously, there is some variation from State to State, as Under Secretary Veneman suggested. This explains why only 30 percent of the facilities were labeled substandard in Minnesota. It also serves to underline the importance of the subcommittee's Minnesota hearings which were an in-depth analysis of nursing home abuses in a State with the reputation for high quality nursing home care.

Clearly, there is compelling evidence to support the subcommittee's conclusion that more than 50 percent of the nursing homes in the United States are substandard (with serious and life-threatening conditions). Indeed, the conclusion would be supportable if the only data available was the HEW study showing at least 59 percent of U.S. nursing homes are deficient from the standpoint of fire safety. Fire safety certainly qualifies as a life threatening (as opposed to technical) violation. The conclusion has already been reinforced by two major nursing home fires in 1974: six died in an August fire in Brookhaven, Miss., and seven died in a September fire in St. Joseph, Mo.[187]

In the final analysis, the precise percentage of substandard homes is not the issue. If only a "fringe" of the Nation's 23,000 long-term care facilities is substandard, there would still be a

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[184] Page 1982, part 18, hearings cited in footnote 1.

[185] "Enforcement of the Life Safety Code in Skilled Nursing Facilities," January 1974 report by the Office of Nursing Home Affairs, Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health, Education, and Welfare; *Washington Post,* January 16, 1974, p. A9.

[186] *Washington Report on Long-Term Care,* June 14, 1974. See also full statement of Gregory J. Ahart, Director, Manpower and Welfare Division, before the Special Studies Subcommittee, House Committee on Government Operations, June 11, 1974.

[187] *Washington Report on Long-Term Care,* September 13, 1974.

desperate need for reform. The time for denials and mutual recriminations is long past. It is time for operators and consumer advocates to work together in the spirit of trust and good will if there is to be an improvement in the quality of life for the Nation's 1 million nursing home patients.

(For recommendations, see p. 227.)

PART 3

AN EXAMINATION OF THE ROOTS OF CONTROVERSY

Few words strike more fear into the hearts of the elderly than: "nursing homes."

In the abstract, the words suggest humanitarian ideals applied to the safety and comfort of those badly in need of compassion and competence.

And yet, in the minds of many, just the opposite impression exists, so much so that emotionalism clouds almost any discussion of issues related to long-term care in the United States today.

Part of the fear response is caused by reports of abuses and shortcomings in meeting standards, as described in Parts 1 and 2 of this report.

But deeper causes also play significant roles. Congress, in any consideration of policy issues related to the treatment of chronic illness among the elderly, must take those causes into account.

Part 3 of this report, therefore, deals with:

- Effects of negative attitudes toward aging and—in particular—to those in long-term institutions, the so-called dumping grounds for the dying.
- The tug-of-war between the industry and its critics, and the frequent defensive posture on the part of the industry, caused in part by the preponderance of profitmaking institutions in the provision of long-term care.
- Unresolved issues related to the place of the industry in the overall health system of our Nation.

I. WHY THE FEAR RESPONSE TO AGING AND TO LONG-TERM CARE

> —"I find that the reasons why old age is regarded as unhappy are four: it withdraws us from active employment; it impairs physical vigor; it deprives us of nearly all sensual pleasures; it is the verge of death."
>
> —Cicero (106–43 B.C.)

Cicero's somber appraisal might be challenged by some gerontologists today who find that the elderly, in general, are far less gloomy about aging than most people think, and the elderly of the not-to-

distant future will find far more fulfillment than fear in their retirement years.[188]

(Even Cicero's description of aging—taken from his classic discourse, "De Senectute"—is not as final a judgment as it appears. It is merely the starting point for a description of the many rewards of aging, despite deep-rooted impressions to the contrary.)

No matter how optimistic some appraisals of aging may be today, however, even these writings usually acknowledge that widespread deprivation and serious problems face large numbers of elderly, so many of whom must cope with reduced circumstances and failing health, as well as fundamental changes in society and family life.

These problems are especially pronounced for those who are in institutions or who may require an alternative, if one is available.

As was seen in the Introductory Report [189] to this series of Supporting Papers, persons in this "at risk" group quite often have exceptionally limited resources, and most are 75 years of age or older, constituting the most rapidly growing age segment which is highly vulnerable in many respects.

This large population of very old Americans with a high incidence of chronic illness is—as we have seen—a fairly recent development; and in some ways the present nursing home industry has developed in stop-gap fashion to meet needs caused by unprecedented age and social patterns.[190]

A major complicating factor in the development of that industry, however, has been the deeply negative attitude toward aging in the United States, an attitude described again and again at hearings by this subcommittee and a very real factor in almost any issue related to aging.

In the case of long-term care, however, that attitude becomes even more pronounced and harmful.

A. AGE-ISM: DENIAL AND DESPAIR

Society's view of nursing homes is affected by society's view of aging in general.

Usually, in testimony before this subcommittee or other units of the Senate Committee on Aging, the argument is made that the United States is "youth-oriented."

The reasons suggested are varied:

- The break up of old family patterns leave no real "role" for the elderly.

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[188] See, for example: "Successful Aging in 1970 and 1990," by Bernice Neugarten, Ph. D., professor and chairman, Committee on Human Development at the University of Chicago, in *Successful Aging: A Conference Report*, Duke University Center for the Study of Aging and Human Development, 1974. Also: *Retirement in American Society,* by Gordon F. Streib and Clement J. Schneider, S.J., Cornell University Press, 1971; and pp. 4–5 of *Aging and the Professions, Vol. II of Aging and Society,* edited by Matilda White Riley, John W. Riley Jr., and Marilyn E. Johnson, Russell Sage Foundation, 1969.

[189] *Nursing Home Care in the United States: Failure in Public Policy,* Introductory Report, November 1974.

[190] In 1900 there were 3 million older Americans. Today there are 21 million, or a 600 percent increase in just 74 years. One out of every 5 seniors can expect to spend some time in a nursing home prior to death. Changing living patterns are just as evident as increased population. For example, the turn of the century is perhaps the transition of the United States from an agrarian to an industrial society. The change to urban environment, industrial employment and the mobility that came with the automobile, all served to undercut the extended family concept and the traditional role of the elderly.

- The demand for earlier retirement, caused in part by the pressure to "make way" for younger persons to claim their share of the job market.
- Resistance to any sign of age; gray hair, fading physical powers, and even the equation of retirement with idleness, or—worse—being "non-productive."

Going farther in analysis of the phenomenon, Dr. Robert Butler of Washington, D.C., has argued that "age-ism" exists in the United States, and it is a particularly potent form of bigotry.

He writes:

> Age-ism reflects a deep seated uneasiness on the part of the young and middle-aged—a personal revulsion to and distate for growing old, disease, disability, fear of powerlessness, uselessness, and death.[191]

Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care, recently made a similar point:

> It's hell to be old in this country.
>
> I heard someone say that not long ago. It's the simple truth—for most of our elderly.
>
> The pressures of living in the age of materialism and the pursuit of the good life have produced a youth cult in America. Our preoccupation with staying young knows virtually no boundary. We spend millions on elixers and remedies all the way from pep pills to hair transplants and face liftings. Hang the expense. Drink Pepsi, drive a Ford, smoke Silva-Thins, or do anything else anybody insists will keep you looking young.
>
> Why this obsession with youth? Some blame the movies. Others blame advertising for the kind of images sold to the public. The real reason goes deeper. Most of us are afraid of getting old. This is true because we have made old age in this country a wasteland. It's T. S. Eliot's rats walking on broken glass. It's the nowhere in between this life and the great beyond. It's being robbed of your eyesight, your mobility, and even your human dignity.[192]

Dr. Carl Eisdorfer, professor and chairman, Department of Psychiatry, University of Washington School of Medicine, states that the treatment of nursing home patients is only a reflection of current attitudes toward the elderly in this "no-deposit, no return society."[193]

Dr. Butler's later writings on age-ism probed deep into possible causes:

> In the West, death is considered as *outside* of the self. To be a self (a person) one must be alive, in control, and aware of what is happening. The greater and more narcissitic

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[191] In "Age-Ism: Another Form of Bigotry," p. 243, *The Gerontologist,* Vol. 9. No. 4, Part I, Winter 1969. Dr. Butler is a research and practicing psychiatrist, psychoanalyst, and gerontologist. He is on the faculty of Washington School of Psychiatry, Howard University School of Medicine, and Washington Psychoanalytic Institute, Washington, D.C.

[192] Congressional Record, November 22, 1971, p. S19406.

[193] "View of Old Age: No Deposit, No Return," *Modern Nursing Home,* September 1972, p. 59.

> Western emphasis on individuality and control makes death an outrage, a tremendous affront to man, rather than the logical and necessary process of old life for new . . . the Western predilection for "progress," conquest over nature and personal self-realization, has produced difficult problems for the elderly and for those preparing for old age.
>
> This is particularly so when the national spirit of the country and the spirit of this period in time have emphasized and expanded the notion of measuring human worth in terms of individual productivity and power. Old people are led to see themselves as "beginning to fail" as they age, a phrase that refers as much to self-worth as it does to physical strength." [194]

Butler and a coauthor, in 1973, also saw a possible connection between early forms of research on aging and negative attitudes that are particularly intense for the institutionalized elderly:

> Until 1960, most of the medical, psychological, psychiatric and social work literature on the aged was based on experience with the sick and the institutionalized, even though only 5 percent of the elderly were confined to institutions. A few research studies that have concentrated on the healthy aged give indications of positive potential for the entire age group.
>
> *But the general almost phobic dislike of aging remains the norm, with healthy old people being ignored and the chronically ill receiving half-hearted custodial care.* Only those elderly who happen to have exotic or "interesting" diseases or emotional problems or substantial resources ordinarily receive the research and treatment attentions of the medical and psychotherapeutic professions. (Emphasis added.) [195]

Dr. Butler's thesis about age-ism has received widespread attention in professional journals and elsewhere. He and those who concur with his findings call for greater rationality and preciseness in discussing the actual physical condition and psychic outlook of persons in or near retirement age.

B. ATTITUDES TOWARD INSTITUTIONS

Negative attitudes toward aging are sometimes directed by the elderly at themselves: "I don't want to get in the way," is one expression of that attitude.

Another is: "I don't want to be a burden."

These feelings of diminished self-worth may be intensified by the prospect of institutionalization.

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[194] *Aging and Mental Health: Positive Psychosocial Approaches,* by Robert N. Butler and Myrna I. Lewis. C. V. Mosby Co., 1973, p. 17. See also the following testimony of Dr. Victor Kassel in part 7, hearings cited in footnote 1, p. 564: . . . Too often during the past seventeen years, I have seen an elderly lady with arthritis return to an inadequate social environment at home with a hostile milieu. Upon arrival, the patient becomes depressed, and with the depression, further limitations in physical activity. Increased impairment from the arthritis results. A plain example of social pathology increasing organicity. I need not remind you that psychological dysfunction can produce organic changes, as for example a peptic ulcer; nor need I remind you that organic disease can produce functional difficulty, an acute myocardial infarction resulting in anxiety and depression. Widening our perspective of patients' needs to include the needs produced by social pathology enables us to realize that the third factor too is important. Social pathology produces further organic impairment; social pathology produces further psychiatric impairment; and in a vicious cycle, all three pathological categories destroy the patient.

[195] See testimony of Dr. Butler in part 11, hearings cited in footnote 1, pp. 905–09.

Indeed, for many, nursing home placement may well represent the accumulation of all the fears of a lifetime rolled into one.

The fear of nursing homes is complex, penetrating both the conscious and subconscious levels of awareness. Some fears are almost primal, such as the fear of helplessness, hopelessness, insanity, and death. Others relate to what the aged hear, see, and read.

The Fear of Change and Uncertainty

Shock occurs when plants and animals are uprooted. A similar effect is experienced by the elderly when they are removed from their homes and placed in long-term care facilities. Numerous studies have traced the increase in mortality and morbidity associated with placement in the nursing home. The phenomenon is termed "transfer or transplantation shock." [196]

The Fear of Using Up Their Savings, of "Going Broke," of "Going on Welfare," and Becoming a Burden Upon Their Families

As documented in the Introductory Report, the average nursing home costs $600 a month and the average retired couple has about $310 in monthly Social Security income. It is clear that few seniors can afford to pay for the cost of care. Those who attempt to do so will quickly use up whatever savings or assets they have. Accordingly, many elderly fear that a nursing home stay will reduce them to poverty or to reliance on family for support. Even worse, it may force them to "go on welfare" (to accept the assistance Medicaid offers to indigents). For seniors who lived through the great depression and abide by the Puritan work ethic, poverty is a "disgrace," and the alternative of becoming a burden on the family is an even greater tragedy. To add to this tragedy, many aged feel that the expenditures for nursing home care are senseless since they have seen comparatively few of their peers restored, rehabilitated, and returned to the community.

The Fear of Losing Their Liberty, Identity, and Human Dignity

In the minds of many seniors, entry into a nursing home is associated with the loss of rights, prerogatives, and privileges. Choices become fewer and fewer. Many find they cannot do what they want when they want to do it. Most of all, they cannot go home. It is regarded as a regulated and regimented existence.

The aged fear a loss of identity when they leave behind the security of a familiar environment. Many homes forbid their patients to bring furniture, photographs, jewelry, and other possessions—all the mementos of a lifetime.

With the loss of identity, freedom, and independence, seniors perceive that a forced divestiture of their personal possessions and even aspects of human dignity has occurred. Such total divestiture has been

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[196] Paper presented by Mary L. Hemmy, executive director, the Benjamin Rose Institute, Cleveland, Ohio, at an Institute on Nursing Service Administration for Long-Term Care Facilities, American Hospital Association, January 19, 1965, in Chicago, Ill.

described as "social death" by Barney G. Glaser and Anselm L. Strauss in the book, "Time for Dying."

The Fear of Becoming Insane

Dr. Herb Shore, administrator of Golden Acres, Dallas, Tex., and former president of the American Association of Homes for the Aging, has written about old people caught up in the "vicious cycle of senility." It begins with "others" demanding that the aging person abdicate his accustomed roles in life. This decreases his sense of worth, which in turn, is followed by failing health and/or initial signs of brain damage. At this point, "others" insist that the aging person become dependent upon various institutions for "care and protection." This action further decreases his sense of identity and worth because of the social stigma associated with institutionalization. At this point, the aged person reacts by becoming "confused," "docile" or "uncooperative." Then the aged person begins to accept as fact this imposed sense of self-worthlessness, further retreating into the past and losing meaningful concern for the unpleasant present. Consequently, the aging person is labeled as "unreachable" or "hopelessly senile"; "vegetation" and death follows directly.[197]

The great majority of nursing home patients (estimates vary from 55 to 80 percent) are mentally impaired, and the elderly realize that exposure to them may result in their own deterioration. Witnesses at subcommittee hearings have confirmed that mixing the physically ill with the mentally ill has the effect of reducing patients to the lowest common denominator. In St. Paul, Minn., one patient jumped to her death from the nursing home's third floor because the home gave her a roommate who spanked her fellow patients as "her babies," ran around with her dress up over her head, and drank from the toilet.[198]

The Fear of Poor Care and Abuse

The elderly in nursing homes are completely dependent on their caretakers. Many have no friends, relatives, or visitors. Because of the many negative stories about nursing homes, senior citizens are more than a little afraid of poor care and abuse. This has been fortified in many cases by first-hand experience.

The Fear of Death

In the final analysis, the aged fear nursing homes because of their intimate connection with death. It is to nursing homes that the ill elderly are sent in their final hours. Some 27 percent of those entering a nursing home, in one study, died within the first month of their stay.[199]

How do the elderly feel about death within an institution?

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[197] Chart presented to Val J. Halamandaris by Dr. Shore, October 31, 1971.
[198] Page 2301, part 19B, hearings cited in footnote 1.
[199] Study by Dr. Morton A. Leiberman, University of Chicago, quoted in part at page 778, part 9, hearings cited in footnote 1.

In a survey by the University of Southern California, 61 percent preferred to die at home, 31 percent at the hospital and only 2 percent preferred dying in a nursing home.[200]

For all the above reasons, the average older American regards nursing homes as a kind of purgatory, as the first step of an inevitable slide into oblivion. Nursing homes become synonymous with death and the notion of protracted suffering before death.

C. HARSH REALITIES ABOUT AGING

Attention has already been paid (in the Introductory Report) to the high incidence of disabling illness among institutionalized older persons, including a high rate of mental illness.[201]

Many older persons find it difficult to describe the loss of physical powers and the onset of actual semidisability. It is a slow process, usually. In many ways, it is insidious.

An impressionistic account of the sensory losses which occur with aging was recently provided in a recent *Atlantic Monthly* magazine article written by a younger person who had apparently conducted extensive research on the subject. She wrote:

> Aging paints every action gray, lies heavy on every movement, imprisons every thought. It governs each decision with a ruthless and single-minded perversity. To age is to learn the feeling of no longer growing, of struggling to do old tasks, to remember familiar actions. The cells of the brain are destroyed with thousands of unfelt tiny strokes, little pockets of clotted blood wiping out memories and abilities without warning. The body seems slowly to give up, randomly stopping, sometimes starting again as if to torture and tease with the memory of lost strength. Hands become clumsy, frail transparencies, held together with knotted blue veins.
>
> Sometimes it seems as if the distance between your feet and the floor were constantly changing, as if you were walking on shifting and not quite solid ground. One foot down, slowly, carefully, force the other foot forward. Sometimes you are a shuffler, not daring to lift your feet from the uncertain earth but forced to slide hesitantly forward in little whispering movements. Sometimes you are able to "step out," but this effort—in fact the pure exhilaration of easy movement—soon exhausts you.
>
> The world becomes narrower as friends and family die or move away. To climb stairs, to ride in a car, to walk to the corner, to talk on the telephone; each action seems to take away from the energy needed to stay alive. Everything is limited by the strength you hoard greedily. Your needs decrease, you require less food, less sleep, and finally less human contact; yet this little bit becomes more and more difficult. You fear that one day you will be reduced to the simple acts of breathing and taking nourishment. This is the

[200] "Elderly Care Wishes Are Two Extremes," *Washington Post,* November 3, 1970.
[201] See Supporting Paper No. 7.

ultimate stage you dread, the period of helplessness and hopelessness, when independence will be over.[202]

In addition, this group may be confronted with crises calling for deep-rooted adjustments; separation from children, loss of spouse or friends, reduced incomes, and the growing feeling that their problems are of little interest to others.

Many studies have concluded that the institutionalized elderly, as compared to persons living in the community generally, have a markedly impaired level of overall adjustment, a reduced capacity for independent thought and action, a depressive mood, and low self-esteem.

Witnesses before the subcommittee have suggested that patients with chronic illness often have, in effect, an institutional syndrome, which one witness summed up as follows:

1. Pain and decreased ability are observed by the patient.
2. Fear of pain, helplessness, doctors, and institutions is increased when the patient realizes he must seek help.
3. Uncertainty and confusion develop when ailments persist after treatment.
4. Loneliness for familiar faces, things, and the "good old days" increase when the patient is isolated in an institution and has little else to think about.
5. Boredom soon becomes a problem when there is nothing to do, little to anticipate, monotonous menus are anticipated, and the institutional routine is habitual.
6. Despair deepens when deteriorating conditions become obvious and resist correction.
7. Dominating hopelessness shadows optimism when the patient sees other patients deteriorate and die—he thinks "here they are—I am here—they get worse—what hope have I".
8. Irreversible helplessness—physical, psychological, and social—result from inactivity in a barren and impotent environment.
9. Some patients have "willed" their death, become critical and died.[203]

D. THE "IATROGENIC DISEASES OF INSTITUTIONAL LIFE"

Fear about a nursing home often arises even before an elderly patient is placed there.

Anticipation may be far more vivid than the actual reality. But the institutional routine may have its own perils.

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[202] "Aging in the Land of the Young" by Sharon Curtin, *Atlantic Monthly*, July 1972, p. 67. For a description of an experiment in simulating sensory deficit of the elderly, see testimony of Professor Leon Pastalan and associate, pp. 4–13, part 1, hearings on "A Barrier-Free Environment for the Elderly and the Handicapped," U.S. Senate Special Committee on Aging, October 18, 1971, Washington, D.C. One young student who wore devices simulating such sensory losses said: "The greatest impact in terms of hearing loss was in feelings of insecurity resulting from uncertain sounds. Noises from down the hall sounded much like noises only a few feet away, and most voices at a distance were difficult to identify." He said his part in the experiment would affect his own professional attitudes as an architect later in life, a statement indicating that similar experiences or experiments could be helpful in the training of nursing home personnel.

[203] Page 576, part 7, hearings cited in footnote 1.

Elaine M. Brody, director of the Department of Social Work at Philadelphia Geriatric Center, has written widely about the need to raise standards in long-term care facilities. That center is regarded as a model in the development of coordinated health and social services. Her analysis of the positive and negative impact of nursing homes is, therefore, based on professional experience and acquaintance with high standards.

She asserts, "the age-ism that pervades attitudes towards all the elderly is intensified with respect to those institutions," [204] partially because of the many frailties of the elderly, institutionalized population.

Built into Mrs. Brody's view of institutional life are the iatrogenic diseases, or those induced in the name of healing.

She writes:

> Some sense of power—some degree of control over one's own destiny is critical to the integrity of the human personality. The new resident, by virtue of age-status, "pauper-status," patient-status, his losses and impairments, already has experienced an erosion of his sense of autonomy or self-direction. *The institution actively participates in reducing the resident to total lack of power.* The fact that most often it is the place of last resort, in itself gives power to institutional management and staff. After all, where will the old person go if he doesn't like institutional life? [205] (Emphasis added.)

Mrs. Brody describes procedures that transfer the individual's power over his own life to the personnel of the institution:

> The new resident of a nursing home or a home for the aged or his family members may sign a medical "permission to treat" form that will be in effect sometimes for many years. Often, medications formerly self-administered are removed. Alcoholic beverages, cigarettes, and certain foods may be prohibited. There are few options about such basic activities as rising and bed-times, mealtimes, and menus.[206]

Her list of other factors in "what might be called the iatrogenic diseases of institutional life" are: dependency, depersonalization, low self-esteem, lack of occupation or fruitful use of time, geographic and social distance from family and friends, inflexibility of routines and menus; loneliness; lack of privacy, identity, clothing, possessions and furniture; lack of freedom; desexualization and infantilization; crowded conditions; and negative, disrespectful, or belittling staff attitudes.[207]

She adds:

> If there is loss of cultural identity as well, it must be placed high on the list of deprivations.[208]

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[204] In a paper prepared for the National Conference of Jewish Communal Service, Philadelphia May 29, 1973, called "A Million Procrustean Beds." Mrs. Brody recalled Procrustes, "a legendary highwayman of Attica who tied his victims upon an iron bed and stretched or cut off their legs to adapt them to its length.

The modern-day translation of that legend into current nursing home practices may not be exact, but according to Mrs. Brody it has similarities.

[205] See paper cited in footnote 204.

[206] See paper cited in footnote 204.

[207] See paper cited in footnote 204.

[208] See paper cited in footnote 204.

Mrs. Brody describes as "thoroughly documented," the unhappiness, submissiveness, anxiety, negative self-image, and other indicators of poor adjustment.

Despite all of these negative factors, she reports that "a host of formal psycho-social programs" have been developed to prevent them or to deal with them. In her paper—and in testimony received throughout the subcommittee hearings on "Trends in Long-Term Care"—other professional persons, including industry representatives, have made similar statements: institutional practices *can* and have been changed to better meet the needs of patients *as individuals.*[209]

Dr. Frederick N. Elliot, assistant medical director, Los Angeles County Health Department, sees the basic problem as the changing values of society. He notes that the elderly are confronted with a major transformation of society and culture as they knew it. The pace of such change is so rapid as to be almost unintelligible to the aged. However, many find hope because societal attitudes toward the elderly seem to be shifting.

In the traditional morality of the early part of the 20th century, Dr. Elliot notes that liberty had been defined as "doing whatever you had the strength and cunning to do." Older Americans are very much affected by the puritan work ethic in which individuals are valuable to society in direct proportion to their ability to produce. He contends further that sex had traditionally been tied to procreation. He adds:

> In all these concepts, the old person becomes somebody whose mere existence is a tragedy: he can't exercise liberty, he can't work or produce, he can't procreate. We have no place for him, and our reaction is one of guilt and hostility because we recognize that he is what we are to become. [210]

Dr. Elliot sees hopeful signs for the elderly, claiming that society is in the process of redefining these key values. Liberty has been redefined as freedom to do what you ought to do. This notion recognizes that there are limits to man's trespassing on the environment. He contends that society is beginning to value individuals for their intrinsic worth and not for what they can produce or contribute. Finally he says sex has been assigned other values in society beyond procreation.

II. NURSING HOMES AS A "BLIND ITEM" AND A NEW ENTITY ON THE HEALTH SCENE

The controversy over nursing homes is further complicated because the average nursing home customer has no idea what his money is buying. There are few commodities on the market that are more of a "blind item" than nursing home care. The unknowns encountered are caused, in part, by the fact that the nursing home industry has taken shape primarily during the last 40 years. It is still taking shape but in response to rapidly changing circumstances.

As noted previously, there is little agreement concerning the role this industry should take, and the kind of services it should provide.

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[209] See Supporting Paper No. 6, and part 17, hearings cited in footnote 1.

[210] "Goals for Quality Must be Based on Values Derived From Changing Society," *Modern Nursing Home,* July 1971, p. 33.

Even official definitions fall short of precision, often defining nursing homes by reference to recognizable institutions—as something more than a boarding home and something less than a hospital.

Part of the conflict in defining the essential functions of long-term care facilities may be traced to confusion about the reasons for establishing them in the first place.

As notable an observer as Dr. Shore believes that the early history of institutional services reflects not noble or altruistic motives, but rather a basic societal drive to isolate and remove from view the diseased and the handicapped.

He has written:

> Let us not forget that the true history of our institutional services (both in hospitals and homes) reflects not noble, charitable, and altruistic motives, but rather the efforts of society to isolate and to remove from view the diseased and handicapped. The almshouse of the past was the community collection pot for the orphaned, lame, sick, halt, blind, deaf, aged, and oft times the insane.
>
> Let us not forget that we are still engaged in battling a Calvinistic, puritanical, punitive philosophy that can be traced back to the Elizabethan English Poor Laws; a philosophy that in effect said—pauperism is not to be respectable, relief should be as unpalatable as possible. We stressed repression; we centered responsibility in the local community; we permitted only a minimum of State supervision and control.[211]

Dr. Shore's analysis is supported by other gerontologists. It is supported, too, by the testimony often received from older persons who tell this subcommittee that they regard institutional care with Medicaid assistance as "welfare" or worse. This legacy of misunderstanding continues and adds considerable confusion for those who must select a nursing home for the first time.

Reliable guidance is scarce, thus forcing many to make a "blind" selection.

To the prospective customer, the choice of a nursing home can be truly agonizing.

Looks can be deceiving. A converted frame home in dilapidated condition may provide superlative nursing care. By the same token a new and modern facility may provide poor care or vice-versa. There is virtually no way to tell. Accordingly, patients and family must rely upon the judgments of physicians, social workers, and ministers who themselves are guided almost entirely by limited experience and rumor. The consequences may be severe. One witness before the subcommittee put it this way:

> The senior citizen is carrying the cross when he contemplates entering a nursing home. Whether he is fighting against the good, or carrying it bravely depends not only on his basic

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[211] "New Ideas in Institutional Care," *Professional Nursing Home*, June 1966, p. 56. For additional discussion of the relationship of some modern-day attitudes toward institutions and the early attitudes toward "workhouses" and other facilities designed to make inhabitants as uncomfortable as possible, see paper by E. Brody cited in footnote 202 and "Development of Care of Elderly: Tracing the History of Institutional Facilities," by Jacob G. Gold and Saul M. Kaufman, *The Gerontologist*, Vol. 10, No. 4, Winter 1970, Part I.

personality structure but on the type of nursing home in which he may find himself. The burden can be light and the yoke sweet if he finds himself in a medically oriented, patient-centered home wherein most of his needs are provided for, where he is cared about, and above all, where he has an opportunity for social intercourse.

Life in an inferior type of nursing home can be an intolerable, almost catastrophic burden, with death itself preferable to the inhumane, cold, disinterested, and unprofessional attitude that is passed on to the patients. Many of our senior citizens who need the services of a nursing home may come to regard them as havens of refuge and comfort for the sick and the afflicted rather than a fate worse than death.

. . . Many of today's nursing homes are considered as a cross between an asylum and the Spanish inquisition, masquerading—as the greatest boon ever given to an ungrateful segment of the population.[212]

III. TUG-OF-WAR BETWEEN INDUSTRY AND ITS CRITICS

Attitudes toward aging certainly should play a role in any analysis of long-term care.

Attitudes toward the nursing home industry must be taken into consideration, as well.

There is little doubt that frequent newspaper and television stories of scandal and abuses have a major impact upon the public. For example, the Associated Press in September 1969, wrote:

> Despite a billion-dollar bonanza from the federal government, America's nursing homes are a stark and lonely place to die. Abuses in money and medicine, an air of death and despair shadow the aged through the dusk of their days.[213]

Similarly, on April 8, 1973, the *New York Times* carried an article by Dr. Naomi Bluestone stating:

> Five years in the field began to toughen me. I made the rounds of nursing homes, where the sick and elderly marinated in their own urine or slumped over the arms of that familiar paraplegic roost, the wheelchair. . . . I have learned that this is the way it is to be. I know now that the enemy may be cloaked in the coat of the healer, and the friend will appear from among the lowliest of our society. I have learned how the purse strings which tighten a noose around our theraputic efforts and force us to employ for our elderly those whom no one else will have, do not alone cause our travail. I have perceived that as repression springs from the terrified heart, so untutored voices speaking of euthanasia to try the right of our multiple wrongs. . . . A society that will not care for its mothers and fathers will care just as little for its useless children. Some day we will all be held accountable for what we have done to our parents.

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[212] Page 197, part 2, hearings cited in footnote 1.

[213] By James R. Polk, recent recipient of Pulitzer Prize as reporter for *Washington Star-News*.

There have been more than 50 major newspaper exposés dealing with the subject of nursing homes over the past 14 years. In addition, more lengthy exposés have been offered as books, and their titles are usually eye-catching such as "Where they Go to Die," and "Tender Loving Greed."

The tug-of-war between the industry and its critics, however, is not limited to the media and books.

Consumer and senior citizen representatives have charged that the Nation's nursing homes constitute nothing less than "a national scandal." They assert that the large majority of the Nation's nursing homes do not meet minimum standards, and patients suffer as a consequence. Furthermore, they have produced studies which document widespread abuses, poor and inappropriate care, and charges of profiteering. Such allegations have been examined in the Introductory Report and Parts 1 and 2 of this paper, and individual problem areas will be analyzed in forthcoming Supporting Papers.

Occasionally, a prominent and respected nursing home administrator joins the critics. Paul dePreaux, administrator of Church Homes, Inc., in Connecticut and former president of that State's Association of Nonprofit Homes for the Aged, had words about HEW regulations in testimony before the Subcommittee on Long-Term Care. To make the point that proposed Federal standards were inadequate and would result in low quality care he said:

> It is a sad day when the laws of such States such as Connecticut require more stringent standards for care of poodles than the Federal Government proposes requiring of nursing homes caring for people. The veterinary laws of five States other than Connecticut are definitely more stringent regarding the care of animals than the proposed (Medicaid) nursing home standards would be for the care of our ill aged.[214]

RESPONSE FROM INDUSTRY

Operators reply that government and philanthropy have failed to provide beds for people in need of long-term care, and therefore, there is a role for private enterprise, responding to supply and demand realities.

For example, on the supply and demand issue:

> The natural laws of supply and demand create the fairest prices by encouraging an abundance of competition among facilities that qualify for Medicaid. There is nothing immoral about profit motivating people to provide the best service for the money. . . . The free enterprise system can provide the best combination of quality and cost, encouraging competition among the self-supporting and subsidized facilities.[215]

On the other point:

> Senator Moss. Mr. Miller.
> Mr. Miller. Thank you, Mr. Chairman.

[214] Page 33, part 1, hearings cited in footnote 1.
[215] Testimony of Berkeley V. Bennett, executive vice president, National Council of Health Care Services, at page 607, part 7, hearings cited in footnote 1.

> Monsignor Sellinger, you have made an observation that, in your opinion, the situation constitutes, in effect, an indictment of our entire society as it relates to the elderly.
>
> The question arises, however, when you are discussing the matter of the preemption of the nursing home field by persons who are engaging in it as proprietors for a profit, does this not, in your judgment, connote a particularly strong indictment of those institutions that normally enter into the provision of care through voluntary nonprofit institutions?
>
> Monsignor SELLINGER. Meaning that there hasn't been enough interest on the part of those groups to take care of nursing homes the same way they did with hospitals?
>
> Mr. MILLER. That is right.
>
> Monsignor SELLINGER. I think so. And I think as a result of conversations since the report, it has been our intention to try to interest groups such as have been interested in hospitals to get interested in homes for the aged.[216]

Defenders of the industry assert that criticism and examples of abuse directed at the industry are "isolated instances" not generally reflecting the general pattern of the industry. They retort that the charges are made by untrained observers who are often not prepared for what they see in nursing homes. They imply that the observer is appalled by the decrepitude and frailness of the human condition rather than by the condition of the facilities. Sometimes they have impugned the motives of the investigators.[217] Furthermore, they assert that families and society have "dumped" their unwanted relatives in nursing homes and then castigated the facilities, not because of proven abuses, but because of individual and collective societal guilt.

> Complaints by residents are sometimes valid, and yet, due to the process of aging, they cannot all be accepted as fact. The unfortunate presence of guilt complexes among some of the relatives can very easily cloud the interpretation of comments by those whom they visit, and at the same time, their evaluation might be correct.[218]

Most often, nursing home operators claim that they are doing the best they can, but State reimbursement (Medicaid payments set by State legislatures) is usually insufficient to provide adequate care. Testified one nursing home administrator:

> The nursing home is the vending machine and the welfare department is the customer. If the customer wants the 10-cent bar and puts in a nickel, don't bang on the machine. It gave you what it got.[219]

To this, critics reply that existing rates are more than adequate, and many operators are profiteering by cutting corners on everything from food to linens.

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[216] Exchange between John Guy Miller, minority staff director, Special Committee on Aging, and Monsignor Joseph Sellinger at page 820, part 10, hearings cited in footnote 1.

[217] See Appendix 1, item 3, p. 236, for press release by Metropolitan Chicago Nursing Home Association, also reprinted at page 1543, part 15, hearings cited in footnote 1.

[218] Testimony of J. I. Green, Executive Director, Minnesota Nursing Home Association, at page 2141, part 19A, hearings cited in footnote 1.

[219] Page 621, part 6, hearings cited in footnote 24.

Two factors further complicate the controversy:

—The defensive posture by the industry.

—The conviction on the part of many that the "profit motive" is incompatible with good long-term care.

DEFENSIVENESS BY INDUSTRY

Part 1 described the frequent industry response to newspaper series and television reports or documentaries on nursing home problems. A similar pattern emerged at hearings by this subcommittee.

For example, J. I. Green, executive director, Minnesota Nursing Home Association, testified:

> It would probably be natural for me to want to attack those that have been garbage-mouthing our profession . . . the charges have put a tainted label on the entire profession, a label that's totally unfair, untrue and unwarranted. . . . Can you imagine how a resident might feel when they see or hear the media reports about charges and the investigations and so forth; or can you imagine how a son or daughter might feel, the son or daughter that probably already is extremely guity about placing mom or dad in a nursing home to start with.[220]

On another occasion, Mr. Richard Preston, president of the Florida Nursing Home Association stated:

> Senator, I will go into a little defense. I think the nursing homes in this country and in this State certainly today have been attacked. I think that if you will take the time to go back and read the testimony . . . you will draw the conclusion that these accusations are isolated instances.[221]

In August 1974—after months of leading the opposition against some regulations which would increase nursing home costs [222]—the governing council of the American Nursing Home Association agreed to a name change recommended by the executive board. ANHA will be known beginning January 1975 as the American Health Care Association. Members will pay additional dues, increasing from $2.50 to $3.00 a bed. A "nationwide long-term care image improvement program" will be conducted in 1975 at a total cost of $350,000, financed by a $50 per facility tax increase, approved at the Association's November 1974 convention in Hawaii.[223]

In his November 2 speech before the American College of Nursing Home Administrators, Senator Moss commented: "To my way of thinking, those thousands of dollars could be better used on behalf of the patients from whom it is derived. . . . The removal of the words 'Nursing Home' from an organization which provides such services constitutes an apology for who you are and what you are."

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[220] Testimony of J. I. Green, executive director, Minnesota Nursing Home Association. at page 2140, part 19A, hearings cited in footnote 1.

[221] Testimony of Richard Preston, then president, Florida Nursing Home Association, at pages 214–217, part 2, hearings cited in footnote 1.

[222] *Nursing Homes* of Feb.–Mar. 1974 quotes Dr. Thomas G. Bell, executive vice president of the American Nursing Home Association as praising the unified medicare-medicaid regulations much criticized by consumer representatives [see Introductory Report.] Mr. Bell said in part: "We are encouraged that the regulations reflect the views of the long-term care segment of the health care industry."

[223] Reported in *American Nursing Home Association Weekly Notes*, Vol. III, No. 32 August 30, 1974. See app. 2, p. 239, for more explanation of ANHA's position.

QUALMS ABOUT PROFITS

Eighty percent of the Nation's nursing homes operate for profit. The fact that a nursing home is proprietary does not automatically make it a bad home, any more than a nonprofit home is automatically a good one. (In fact, nonprofit homes have been criticized from time to time on the grounds that they are not as efficient or as up-to-date as the best of the proprietaries.)

But critics of the proprietaries point to the fact that—while the overwhelming majority of nursing homes are for-profit—fully 87 percent of all hospitals in the Nation are nonprofit.[224]

Dr. Butler summed up such criticisms:

> After 15 years of research and practice, I come now to believe that the profit motive must be eliminated from our care systems, including medicine and institutional care and its alternatives. There are many fine and well-intentioned nursing home owners. They are not all miscreants. . . . But the conflict between profit and service is too great to overcome.
>
> Only in the United States and Canada (to my knowledge) is there "commercialization" to use the word of Representative David Pryor (D., Ark.)[225]

Again and again at subcommittee hearings, and occasionally in television and newspaper accounts, this combination of arguments is made against proprietary homes:

> (1) If nursing homes are to make a profit, they must keep their beds full.
>
> (2) The goal of society must be to discharge patients from institutions as quickly as possible, if suitable care or attention awaits them elsewhere.
>
> (3) Therefore, proprietary homes defeat good health care on several grounds; they may tend to defeat genuine rehabilitation; they may cause operators to look upon patients not as persons but as "units" for whom minimum expenditures and maximum reimbursement should be the rule. They may, therefore, tend to cut corners.[226]

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[224] Health Resource Statistics, Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Center for Health Statistics, p. 369.

[225] Page 905, part 11, hearings cited in footnote 1.

[226] See page 837, part 10, hearings cited in footnote 1 for source cited in footnote 50 which states in part (from the report of a board of inquiry appointed by the Maryland Secretary of Health and Mental Hygiene):

1. *The potential problem of profiteering in the nursing home industry.* It seems to this panel that there is a fundamental contradiction between the goals of profit-making nursing homes and the ideals of our society. Nursing homes, if they are to make a profit, must keep their beds occupied. On the other hand, the aim of our society must be to move aged patients out of beds and into the community to lead as normal a life as possible.

Further, the concomitant of substantial size in business in America is political power. In the hearings held by this panel, various indications were heard of influence upon the state government by the nursing home industry. Testimony suggested a very strong "nursing home lobby" exists in the Maryland State Legislature, and that this lobby has had sufficient political power to prevent passage of legislation in Maryland that might set stricter standards for nursing homes. Our investigation disclosed evidence suggestive of political interference with a nursing home inspection. Witnesses testified that an unannounced inspection of Harbor View Nursing and Convalescent Center in Baltimore was called off during the actual inspection. Explanations by the officials involved in the incident about the innocence of the cancellation remain singularly unconvincing.

This board of inquiry notes that Harbor View nursing home is owned by a corporation whose president and director is a member of the Maryland House of Delegates. We do not question that legislators are entitled to have business interests. We do, however, suggest that the possibility of conflict of interest should be examined. Given this kind of worrisome information, this panel must raise the question of how to control such powerful monetary interests. Have we opened our nursing homes to profiteering?

On the other hand, some high caliber, nursing for-profit homes have taken the lead in advancing new treatment and rehabilitation techniques and have also insisted that patients be treated in pleasant and encouraging surroundings. Testimony at subcommittee hearings frequently alludes to innovations made possible by well-paid, competent management and staff in good, if expensive, homes.

Profits in the nursing homes of the United States are examined by a later Supporting Paper in this series.

But it should be recognized at this point that the profit motive is regarded with some repugnance by large numbers of nursing home critics. They believe that it certainly is one of the root causes of controversy in this industry.

SUMMARY

In short, the roots of the nursing home controversy stem in large part from human attitudes toward aging and the aged. This attitude, however, cannot be used to excuse nursing home owners and operators; nor can it condone the continuing and widespread existence of poor care. Those closest to the action should bear the greatest responsibility.

By the same token, there is a national failure to establish a clearcut policy with respect to the infirm elderly. This failure explains why: (1) 3 million aged are without the nursing care they need; (2) current programs are ineffective and poorly administered; (3) preventive medicine receives little emphasis; and (4) responsibility is continually fragmented. The end result is that the States play "musical chairs" with the frail elderly, moving them away from home, away from town, from mental hospital to nursing home, from nursing home to mental hospital, from floor to floor, and from room to room in whatever direction will save the most money.

In conclusion, the negative image of nursing homes is not entirely the responsibility of owners and administrators of facilities. Nor is it entirely the fault of government bureaucrats who have neglected to establish standards and minimum protections. Rather, it is a combination of factors, a tangle which is only partly unraveled. In the final analysis, nursing homes are, and will be, what the American public insists they become.

INITIAL RECOMMENDATIONS*

Many factors interact to produce the litany of nursing home abuses. The following initial recommendations are offered:

1. A national policy must be established with regard to treatment of the infirm elderly. This policy should consider the total needs of the individual, including medical, dental, residential, social and psychological services. The policy should look first to treating the individual in his own home with appropriate housing, congregate living facilities, and home health services. Some consideration should also be given to senior citizens hospitals and day care centers and proposals to subsidize the family to help them care for the elderly ill in their own homes.

2. The present system must be realigned so that greater financial rewards will be available to those nursing homes which provide exemplary care. An excellent rehabilitation program which gets individuals up and around should be rewarded. The Connecticut "points" system is one good positive example of a reimbursement system rewarding good care.[227]

3. Physicians must be involved with the care of patients in the nursing home. Geriatrics must be rapidly advanced as a specialty in the United States.

4. Nursing home personnel must be trained and paid higher wages if they are expected to perform effectively.

5. Effective minimum Federal standards must be developed to replace HEW regulations of January 17, 1974.

6. States must enforce Federal standards as well as their own State standards. However the Federal Government should not rely totally on the quality of State enforcement; a greater Federal presence is required.

7. Nursing home operators and consumer advocates must work together to help reform community opinion. Nursing homes will be more and more important in the future. Reform is essential so that patients will be treated like human beings with dignity and a sense of intrinsic worth.

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*The Introductory Report and all of the Supporting Papers in this series offer initial recommendations, which will be subjected to review before the Final Report is issued.

[227] See Appendix 1, p. 230 for more details of Connecticut points system.

APPENDIXES

APPENDIX 1

Item 1. Progress in Nursing Home Care, by Franklin M. Foote, M.D., Dr.PH[1]

(Reprinted from the Journal of the American Medical Association, October 23, 1967, Vol. 202.)

By classifying nursing homes in five categories by services and resources available and by tying payment for state patients to rates set in relation to this classification, one state has greatly improved the quality of care provided. Nursing, dietary, and medical services have been upgraded, and many more homes are providing other rehabilitative and therapeutic services. Now, after five years, there are more than five times as many beds in homes in the highest class and only one-fifth as many beds in the lowest category.

Because Connecticut is among the states with the highest proportion of licensed nursing homes approved as extended-care facilities under Medicare (171 of 256), an account of statewide efforts to improve services available and quality of care rendered may be of interest to others concerned about convalescent care and long-term rehabilitation of the disabled person.

The state health department has been responsible for licensing nursing homes since 1928. With legislative authorization of specific regulations, it makes inspections and issues, denies, suspends, and revokes licenses. Over the years, both the Connecticut Association of Extended Care Facilities and the Association of Non-Profit Homes have helped in raising standards through workshops, institutes, and courses. The state medical society and the Connecticut Health League (composed of various voluntary health agencies and professional societies) also have had a keen interest in this field of work.

About six years ago in Connecticut all nursing homes were receiving a reimbursement of $7 per day for welfare patients regardless of the kind of services provided. This rate, set by a state commission, caused general dissatisfaction because nursing homes varied greatly with regard to services facilities, and resulting care.

Efforts were initiated to work out a classification system. The association representing nursing homes operated for profit sponsored legislation requiring such a classification in 1961. The legislation was adopted by the general assembly. With the objective of encouraging quality care, a system was developed in cooperation with nursing home leaders and interested physicians. The aim of the classification was to

[1] See "Trends in Long-Term Care," Part 3, Hartford, Conn., hearings held before the Subcommittee on Long-Term Care, January 15, 1970; pp. 313–316; see also: Initial Recommendations, p. 227, for reference to Connecticut point system set forth in this article.

emphasize preventive and restorative services by encouraging (1) activities to keep patients mobile; (2) provision of services by dentists, dietitians, physical therapists, podiatrists, and other therapeutic personnel in addition to the minimum services required by nursing home laws; (3) rehabilitation as an integral component in nursing home care and giving an incentive to those nursing homes that provided added services.

In planning for the classification, the Connecticut State Department of Health sought to provide financial rewards for activities that might help in early diagnosis and treatment of a disease process or might help to avoid further disability or restriction of the patient's usual life pattern.

Existing licensing regulations already required licensed nurses on duty around the clock, provided for a safe and sanitary environment, and required appointment of either a medical director or consultant who would be available in emergencies and would make rounds in the home at least once a month to check on nursing services rendered, diets, and medical care needed. Each patient was required to have a personal physician. A history, medical examination, diagnosis, and medical orders were required within 24 hours after admission. Such a medical evaluation and prescription of care is basic to service and therapy appropriate to the patient's specific needs.

Among Connecticut's 252 nursing homes, 6 are operated by municipalities, 6 by churches or religious orders, 14 by other nonprofit organizations, and 226 by persons or corporations operating for profit. Sizes range from 5 to 275 beds. The average at present is 46 beds.

AWARD OF PLUS POINTS

The kinds of facilities and services for which plus points are given under our classification may be summarized as follows: administration, physical plant, and equipment, 12½; nursing services, 29; medical services, 10; dental care, 5; podiatry service, 2; speech therapy service, 2; laboratory facilities and services, 6½; x-ray department, 5; prescribed physical therapy, 5; dietary department, 8; recreational, spiritual, and occupational therapy, 17. A wide range of services is needed for patients in nursing homes, and sound overall administration is of fundamental importance.

A nursing home receives one plus point when the administrator devotes his entire time to it, another point when he is a college graduate, and two more points if he has a master's degree in hospital administration. Each of these qualifications makes him better prepared to develop and operate a good program. Other examples of points given are as follows: provision of an emergency power supply that is adequate for light, heat, food storage and preparation; preemployment medical examinations that include chest roentgenograms or tuberculin tests; and handrails on both sides of corridors and bathrooms. Additional points are given for having more nurses or nurses' aides than meet the minimum requirements of our regulations. In medical services, points are given for having an organized medical staff and for having regular medical rounds for all patients at least twice weekly.

If there is a program director for recreational, spiritual, and occupational therapy, points are given depending upon the amount of

time spent on this work and the training of the program director. Points are given with regard to craft programs, religious services, special entertainment, and regular scheduling of volunteers.

It is our belief that all of these plus points stimulate better assessment of the patients' medical condition, early recognition of conditions requiring therapy, prevention of deterioration, and help to rehabilitate those who can benefit from such a program.

PATIENT ACTIVITY PROGRAMS

In the early days of this classification system the greatest misunderstanding arose concerning the points given for the recreational, spiritual, and occupational-therapy programs. It is difficult to judge whether such opposition arose primarily from a feeling that anything that might be pleasant was inherently sinful or from a belief that such services were frills that state agencies ought not to encourage.

Listless, apathetic men and women lying in bed or sitting dejectedly in chairs do not produce a therapeutic environment. Such conduct contributes to physiological changes with which prolonged inactivity is known to be associated: interference with optimum carbohydrate utilization, loss of appetite, anemia, loss of muscle tonicity, and absorption of calcium from the bones. The emotional state of healthy persons can adversely affect their physical condition. We thought that this effect was even more serious for disabled and chronically ill persons.

For these reasons we insisted that strong encouragement be given to programs that would motivate patients to take part in activities in their own rooms, even in bed, as well as in group activities. We encourage the use of volunteer aides in proprietary as well as nonprofit nursing homes. Everything possible must be done to get the patients interested and to reawaken their meaningful participation in the world about them. As a result of our efforts, nearly half of the nursing homes in Connecticut now have trained recreation program directors and carry on a fairly complete round of patient activities. Most of the remaining homes have made real effort to carry out at least a portion of these programs.

DEMERITS

Some of the problems faced by those responsible for licensing and inspection are the occasional violations of regulations which are not of a quality or magnitude to warrant legal action that would lead to revoking the nursing home license. The classification system provides demerits or minus points for such violations (Table 1).

TABLE 1.—*Examples of demerits (minus points)*

Nature of failure:	*Demerits*
Patient in nursing home 24 hours without medical orders	5
Inadequate identification record	5
Inadequate medical admission history and physical examination	10
Inadequate medical progress notes	10
Failure to report accidents	3
Failure to report change of supervising physician	3
Less than equivalent of 4 ounces orange juice per day	6
Less than equivalent of 5 ounces meat per day	6
Stained, cracked, chipped, or unclean dishes, trays, glasses	2
Improper storage or care of food	5

In setting up the classification, we consulted with interested physicians and worked closely with officers representing both the proprietary and the nonprofit nursing home groups. The classification represents a compromise between what might be considered ideal and what turned out to be a practical system for our state. Some thought was given to requiring minimum standards for each of the four classes above class E (Table 2), but this idea was strongly resisted by the nursing home representatives and was not included. We have modified the classification over the years, adding certain items and deleting others.

TABLE 2.—1966–67 CLASSES AND WELFARE RATES

Class	Points	Welfare per diem rate
A	45 or more	$10.50
B	35 to 44½	9.85
C	23 to 34½	9.05
D	13 to 22½	7.80
E	0 to 12½	7.60

CLASSIFICATION NOT PARALLEL WITH SEVERITY OF ILLNESS

Connecticut's classification system does not necessarily indicate where the most handicapped, incontinent, bedridden, or senile patients are to be found. There has been a tendency on the part of both welfare department and hospital social service workers to refer patients requiring the greatest amount of nursing and other care to the A and B homes, but these homes cannot carry on a quality program if they accept only this kind of patient. Most nursing home administrators prefer to have a wide variety of patients, including those who are ambulatory, feeling that this makes their institution a more agreeable place both for their staff and for the convalescent or chronically ill persons whom they serve. Also, in some of the semiambulatory patients complications develop which make them more dependent. Rather then transfer such persons, most administrators consider these patients part of their family and try to continue to give them care even after their disabilities advance. Therefore, one finds both very disabled and only mildly ill persons in Class A homes as well as in Class D and E homes.

Table 2 shows the current classes and welfare rates paid under our classification system. One of the results of the classification system is that the accountants who serve the rate-fixing commission now receive detailed financial reports from most of the nursing homes. These reports are used in determining reasonable rates to be paid for state and local welfare patients in these classes of nursing homes. The rates paid are of considerable importance because more than 60% of the patients are on welfare.

The incentive to reduce violations of nursing home regulations is reflected in demerits given in 1966 as contrasted with those given in 1961 (Table 3). Table 4 shows improvements in some of the services and facilities receiving at least 50% of the possible plus points that could be given under the categories listed. We are indeed pleased with the obvious improvements that were effected.

TABLE 3.—DEMERITS GIVEN, 1961 AND 1966

	Number of homes		Number of beds	
	1961	1966	1961	1966
Nursing service	30	7	1,117	365
Dietary service	10	2	636	142
Medical service	14	0	683	0

TABLE 4.—HOMES AWARDED 50 PERCENT OR MORE PLUS POINTS IN 1961 AND 1966

	Number of homes		Number of beds	
	1961	1966	1961	1966
Nursing service	23	184	5,055	9,025
Medical service	4	122	376	6,677
Recreational and occupational therapy	18	110	1,405	6,987
Physical therapy	8	52	969	509

Table 5 shows the comparison of ratings for 1961 and 1966 in Connecticut nursing homes. The differential payments in these homes has helped tremendously in bringing about improvements. Although not all improvements can be attributed solely to the classification system and the payments resulting from it, we are convinced that relatively little would have been done had it not been made possible for nursing home administrators to finance the services required for good patient care.

TABLE 5.—COMPARISON OF RATINGS, 1961 AND 1966

Class	Number of nursing homes		Number of beds in nursing homes	
	1961	1966	1961	1966
A	14	103	1,261	6,690
B	27	63	1,139	2,430
C	88	67	2,603	1,851
D	78	10	2,191	213
E	22	4	531	100
Total	229	247	7,725	11,284

CONCLUSION

The Commission on Chronic Illness in its report, *Care of the Long-Term Patient*,[1] stated: "Since the people it serves are so much at its mercy, the institution which cares for long-term patients must go to great lengths to serve them in accordance with their needs." Quality of care in nursing homes is affected by both administrative and professional interests. In our award of demerits for violations of accepted minimum standards and in the giving of plus points for providing desirable services, we have helped to make it possible for conscientious nursing home administrators in Connecticut to improve considerably the kind of care which convalescent and chronically ill men and women receive in these facilities.

[1] *Chronic Illness in the United States: Care of the Long-Term Patient,* Commission on Chronic Illness, Cambridge, Mass.: Harvard University Press, 1956, vol. 2.

Item 2: Common Carrier: Plight of the Aged Cited in Lack of Services

[By Dr. Victor Kassel]

[The Salt Lake Tribune, Sunday, April 16, 1972]

"And the Lord said unto Cain: 'Where is Abel thy brother?' and he said: 'I know not; am I my brother's keeper?' "

In Utah, we declare we are. The facts assert otherwise. We neglect our brethren, the aged. We refuse to make available essential services. Tragically for the aged, the State of Utah lacks adequate services for them. If only our older citizens were as fortunate as Naomi (Ruth 4:15) "and he shall be unto thee a restorer of thy life and a nourisher of thine old age." One cannot purchase comprehensive geriatric services in Utah, even if he could afford it.

Comprehensive geriatric services are lacking. Truly, Utah is a ghetto; a geriatric ghetto; a geriatric poverty area devoid of adequate services for the aged.

Long before the recent White House Conference on Aging redefined a comprehensive system of appropriate health care, the facts were known. Yet again to reawaken a disinterested nation, the conferees reminded the citizenry.

LIST OUTLINED

Specifically, the services would consist of the following (not a complete list):

1. A visiting nurse service. 2. A homemakers service. 3. Interested physicians who are willing to make house calls. 4. Appropriately constructed apartments. 5. Supervised apartment living. 6. Communal kitchens. 7. Knowledgeable friendly neighbors. 8. Meals-on-wheels, also able to cater minority foods. 9. Available personal transportation. 10. Adequate bus service. 11. Small homes constructed for disabled senior citizens. 12. Day, night, and week-end hospitals. 13. "Baby-sitter" service. 14. Sheltered workshop. 15. A community referral service. 16. Occupational therapy, physical therapy, recreational therapy. 17. Trained volunteers. 18. Nursing Homes with graded care. 19. Skillful Nursing Home in-service training programs. 20. Home health services. 21. Personal care services. 22. Quality geriatric care in the acute hospitals. 23. A policing service concerned with continual high quality care. How many of these are available in Utah?

The aged are denied these necessary services which could help prevent them from deteriorating to a moribund, senile, vegetating state.

Today, the problem is not what can be done for the aged, but rather what is being done.

CRISIS IN CARE

The crisis is in the delivery and not in the potentiality of care. The problems of the aged are not solved simply by an interested physician, an available hospital, and a nursing home bed.

An array of facilities are necessary. The focus of geriatric care has widened to include a network of interrelated services of ancillary people involving a spectrum of well-trained gerontological specialists. The necessary expertise is available at this moment in Utah. Alas, ennui prevails, and the experts will migrate elsewhere.

Three major problems dominate the scene in Utah: income, medical care, and housing. All were detailed in the Utah Report in the White House Conference on Aging. Many longingly await the largesse from Washington, while detractors shout: "Socialism."

Socialism for the rich, capitalism for the poor; and in the meantime our aged citizens are denied service. The aged citizen is a manipulated pawn in national power politics. Sincere people in Washington are frustrated by the "profit-power-oriented" administrators at the grass roots determining services for the needy.

How effective have been the local mental health programs? O.E.O. programs? Who really profited from the minority education program?

AGED BETRAYED

The aged are betrayed, just as the poor are. The barons of health delivery services are staking out their turf in order to determine the king of the medical services; while, the insurance companies compete with the medical school conglomerates. The poverty of services to the aged differs in no way from the poverty of the services to the poor, from the poverty of the services to the minorities.

Where are the committed people who wish to relieve this abysmal social privation of the aged? Do they exist in the federal government bureaucracy? Do they exist in the state legislatures? Are they owners of the "profit-oriented" businesses? Are they office-holding politicians? No.

These individuals are "profit-poor-oriented." What is needed are "service-oriented" individuals. The mores of our culture are turning individuals more and more to "profit-power-orientation."

So the senior citizen finds himself receiving crisis care, but not preventive services. He finds his pension disappearing because of corporate manipulation, or because of inflation.

ABANDONED BY DOCTOR

In the nursing home, he is abandoned by his physician, while the latter inanely jousts against compulsory retirement. We revere the aged, but steal his home by increasing property taxes. We stress the importance of work, yet deny him a job. With euphemisms, state welfare doles out miserly pittances because there are "cheaters." We skimp on the Social Security payments but would confiscate them if he "earns too much." What a magnificent double bind.

Before the 1970 census, it was calculated that there would be 2.8 million people 65 or over alive in 1980. Now it is expected that the population will contain approximately 40 million people 65 and over. Nonproductive parasites.

Our continued neglect will partially resolve the problem. The nursing homes will do our dirty work. We pay them inadequately to insure inferior care. The doctors abandon the patients to insure no medical follow-up.

Behind closed doors we await GEROCIDE. We demand that the nursing homes play the role of the American concentration camps. We expiate our guilt by pointing our finger at the "heartless nursing home operator." Utahans fiddle while nursing homes burn.

Why is it that there are no high quality, comprehensive geriatric services in Utah? Simply because there is no community commitment to develop these services. Despite the facade of concern for the elder citizen, Utahan's actions reveal just the opposite. Utah's priorities are perverted; Utah's concerns lie elsewhere; Utahans are not their brother's keeper. If they were, they would:

DEMANDS OUTLINED

1. Demand the governor budget adequately for high quality, comprehensive geriatric services.
2. Demand that the legislature delegate adequate funds for these appropriate services.
3. Demand that all organized religious groups in the state, because these groups insist that they are "service-oriented," produce pluralistic programs for Utah's aged residents. In addition, demand that these religious groups come forth with cold cash to help finance these services.
4. Hire gerontological specialists and pay them an adequate salary. But first determine specifically that these individuals are "service-oriented" and not "profit-power-oriented."
5. Begin tomorrow afternoon.

The different world of Utah? Utah is not much different; here, too, we neglect our aged. But now we have an opportunity to demonstrate that Utahan's have a commitment of action to the Fifth Commandment: "Honor thy father and thy mother."

ITEM 3. NEWS RELEASE BY HILLEL H. YAMPOL, DIRECTOR, METROPOLITAN CHICAGO NURSING HOME ASSOCIATION, MARCH 2, 1971 [1]

We have asked you to come for two main reasons: One, we want to comment on the recent and continuing charges by BGA about nursing homes and two, we want to focus the public attention raised by these charges toward real problems and real solutions.

The nature and specifics of the charges have to be qualified. They are being made by untrained observers and reflect, in part, lack of knowledge. They are rampant with dramatic exaggeration, obviously, for effect. They are, so far, unsubstantiated by any responsible agency. They appear to have political implication and perhaps political motivation.

If any of the conditions do, in fact, exist . . . we condemn them! We know they are not representative of the industry. At the same time, we would be foolish to deny the possibility that, as in any profession or industry, a fringe percentage of "undesirable" practices may occur.

We welcome and stand ready to assist appropriate authorities to investigate and stop such practices, if found. We will resist, however, conclusion and trial by newspaper. While we condemn and will vigorously pursue bad practices wherever they might exist, we also condemn irresponsible, panic response by any official or agency to initiate action based on the "Kangaroo Court" of unsubstantiated newspaper articles.

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[1] See "Trends in Long-Term Care," Part 15, Chicago, Ill., hearings held before the Subcommittee on Long-Term Care, Sept. 14, 1971; pp. 1543–1544.

We never have nor will we protect violators but we will move to assure fair and responsible investigation prior to action.

Internally, all charges have been referred to our ethics committee for immediate investigation and hearings. We will seek to get supportive facts from the B.G.A. as well as from other investigative agencies with whom we cooperate.

As to the charges—some points must be raised.

Patients and families have freedom of choice. If such conditions actually existed, why didn't they move? If they had no family, why didn't their case worker, who is supposedly in constant contact, move them? Institutions cannot function if no one uses them.

The Health Department is responsible for inspection, enforcement and consultation. In Chicago this is intensive (at least monthly) and effective. Such conditions could not long go undetected.

On a state level, the governor has now called for monthly inspections of Nursing Homes. Yet last year when public health requested increased funds for more personnel (which we actively supported) it was denied.

The austerity program not only held Public Health in check but froze the hiring and replacing of public aid personnel. This left many case loads unassigned and others covered by untrained and unqualified workers.

A recent court order requiring Public Aid to determine recipient eligibility within 30 days of application forced a major reassignment of Public Aid staff to "intake" procedures.

State government is simply not providing enough money for adequate staffing and care (Example: Illinois is the 3rd wealthiest state in the country but 16th in nursing home rates.) The President and the Governor are seeking a total revamp of welfare because funding and programs are ineffective.

It is not our purpose to cast aspersions on our sister facilities—the non-profit homes. We must note, however, that something wrong was found in every facility visited but since none were non-profit, the blame could conveniently be placed on "profit motivated" proprietary facilities.

We have long sought, in cooperation with others, to upgrade care through strengthening programs, standards and funding. Much of this is new, its full effects are not yet felt. We proudly claim our leadership role in this regard.

We worked for over a year in the development of new state standards—often advocating higher standards (a matter of record) than the state departments would support.

We supported the act requiring licensure and training of Nursing Home Administrators and resisted pressures to delay its implementation. This law adds major strength to enforcement of standards in facilities.

We helped form and are members of the Joint Board for Long Term Care: the Standards and the Mental Health Committee's of the Long Term Care Advisory Council to Public Health (state); The Cook County Public Aid Nursing Home Association Joint Committee; the

nurses aid and cooks aid training programs of the Chicago Board of Education.

We have established our own employment verification service. Rehabilitation Nursing Course, and professional consultation services in Dietary, Occupational Therapy, Social Work and Activities.

We provided over 20 days of educational programs for administrator and key staff in 1970 and have scheduled more for 1971.

However, we urgently but unsuccessfully tried to establish

1. A certified community course for nurses aids entering the field.

2. Recognition of and a special course for medication technicians.

No organization or agency in Long Term Care can match this evidence of "commitment to improvement." We offer our cooperation and challenge any responsible group to join us in solving the real problems in community health care.

APPENDIX 2

LETTER FROM WILEY M. CRITTENDEN, JR., PRESIDENT, AMERICAN NURSING HOME ASSOCIATION, DATED NOVEMBER 21, 1974; TO SENATOR FRANK E. MOSS; AND REPLY FROM SENATOR MOSS, DATED DECEMBER 3, 1974

DEAR SENATOR MOSS: On behalf of ANHA I would like to express to you our hope that the recently released report of your subcommittee will help bring about the positive results which we are seeking.

I believe that the coming debate on national health insurance will offer an opportunity for appropriate legislative action in the area of long term health care. You can be assured of the support of our association for your efforts to secure appropriate recognition of this unmet need.

As you know, ANHA is making plans for a high level conference next June to bring together professionals, consumers, and public officials to explore immediate as well as long range solutions to the problems of health care for the elderly.

In addition, ANHA will be conducting a national image improvement campaign in 1975. In several of your recent statements, you have implied criticism of this effort as well as the decision to change the name of ANHA.

I am concerned that we might have failed to adequately explain the rationale and purpose of these two actions.

Regarding our effort to improve the public image of nursing homes, we believe this program will be consistent with recommendation number twelve on page 111 of your subcommittee report which states:

> Policy makers, providers and the public must work together to improve the "image" of nursing homes. This realignment of public attitudes must begin with the recognition that nursing homes have an important and vital function to perform in society. Moreover, it is absolutely essential to remove the present negative connotation to allow nursing homes to perform more effectively as a part of the American health care continuum.

For this reason we are somewhat puzzled by a seemingly contradictory statement of page 11 of the report, stating that:

> It is time for providers of care to rise above mere public relations campaigns and join with senior citizen spokesmen and Government officials in working for more positive improvements.

I want to assure you, Senator Moss, that our image improvement program is motivated by concerns identical to your own, and will be more than a mere public relations campaign.

It is my earnest belief that a coherent national policy on health care for the elderly cannot be implemented unless there is a dramatic improvement in the public's understanding and concern for its citizens who are in our facilities. Senator Percy mentioned yesterday his distress at finding so few visitors in the nursing homes he had visited in his state.

In a sense, he summarized the purpose of our 1975 campaign—a conscious effort to inform the public about the role of nursing homes and to induce people in communities all over America to take a new interest in the lives of our residents. We believe our efforts will complement the purposes of your subcommittee report by contributing to a new public awareness of the dimensions of a complex problem of our society.

This obligation of funds was voluntarily undertaken by our membership and will be devoted solely for the purpose of improving the image of nursing homes through greater public understanding and community involvement.

The second recent action to which you have referred is the name change of ANHA to the American Health Care Association. This change was made with three major considerations in mind—

(1) the generally pejorative connotation of the term "nursing home" in our language;

(2) the diversification of ANHA member facilities into new services and specialized care on both an institutional and noninstitutional basis; and

(3) the desire to bring about a change of emphasis from the physical plant to the concept of care for the totality of health and health-related needs of the chronically ill of all ages.

The substitution of the words "health care" for "nursing home" reflects not only a trend that is currently underway, but expresses an optimism that future government programs will allow us to begin to use our resources in new ways such as day care, home health, nutrition, and preventive services.

Senator Moss, I hope I have communicated to you the positive feelings we have about our course of direction in the immediate future. I would welcome the opportunity to discuss these issues with you personally at your earliest convenience.

The needs of our elderly citizens over the coming years will place increasing demands on our system of health care. It is imperative that carefully considered programs be implemented in the near future—programs which are both comprehensive and cost-effective. You can be assured of the continued active involvement of ANHA (and ANCA) in achieving this goal.

Respectfully,

WILEY M. CRITTENDEN, Jr.,
President.

DEAR MR. CRITTENDEN: Your letter of November 21 which commends the subcommittee on its report, expresses the hope for broader nursing home coverage within the context of national health insurance and explains ANHA's "public relations campaign" has been received.

You have my sincere thanks for your warm praise of our Introductory Report. I appreciate your very strong commitment to improving the quality of life for the Nation's infirm elderly. I believe your proposal for a June Conference on Long-Term Care is thoughtful and constructive, particularly if an effort is made to involve consumer and senior citizens organizations in the planning of the event.

I also share the hope that we can work together to incorporate expanded nursing home and home health coverage within the context for this goal in the next Congress.

I would add my thanks for the courtesy of an explanation behind ANHA's name change and for some exposition of the term "public relations campaign." I agree with you that the image of nursing homes needs improving. I apparently disagree with you as to *how* that improvement is brought about. It can be achieved through substantive reforms or through the medium of public relations. The term public relations is, of course, very broad and may or may not be based on vigorous in-house reforms. I believe it is these substantive improvements which the association should emphasize rather than the appearance of reform; to wit; a name change to the American Health Care Association.

Once again, I am grateful for the opportunity to exchange views with you.

With best wishes,

Sincerely,

FRANK S. MOSS,
Chairman, Subcommittee on Long-Term Care.

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